Pre-Learning Plan Performance Measure DATE: 1 = less than competent 2 = competent 3 = more than competent	**DIABETES EDUCATOR APPRENTICE SELF ASSESSMENT <name>_____** **Objective:** To meet the Level 3 requirements for Diabetes Educators as established by the American Association of Diabetes Educators (adapted from *AADE Competencies for Diabetes Educators and Diabetes Paraprofessionals* , 2016). ***Upon completion of this form, your Training Plan Document must include: 1- Plan for completion of ADCES (formally AADE) CORE Concepts Course or other pre-approved Board equivalent course 2- Plan of action for anything marked as "less than competent" on self-assessment form 3- Any other individualized training to complete education including but not limited to anything required for the applicants specific job duties*** **Note that each numbered Objective below carries through to all higher practice levels.** (For example, Objectives in Level 1 carry through to Level 2 and Level 3)	Post-Learning Plan Performance Measure DATE: 1 = less than competent 2 = competent 3 = more than competent
	Domain 1: Pathophysiology, Epidemiology, and Clinical Guidelines of Diabetes Competency: Demonstrates familiarity with pathophysiology, epidemiology, and clinical guidelines of diabetes consistent with Diabetes Care Provider Level 3.	
	Level 1	
	Pathophysiology	
	1. Describes normal glucose metabolism.	
	2. Explains the pathophysiologic mechanisms responsible for the development of prediabetes, type 1, type 2, and gestational diabetes.	
	3. Explains the signs and symptoms of acute hyperglycemia, hyperosmolar hyperglycemic state (HHS), and diabetic ketoacidosis (DKA).	
	4. Identifies causes of hypoglycemia.	
	5. Identifies common risk factors for the development of the acute and chronic complications of diabetes.	
	Epidemiology of Prediabetes and Diabetes Disease State	
	1. Recognizes local prevalence of prediabetes and diabetes in the community, county, and/or state.	
	2. Identifies groups at risk for acute and chronic complications.	
	Clinical Practice	
	1. Applies current principles of evidence-based practice.	
	2. Participates in the evaluation of program, unit, or agency processes.	
	3. Updates workplace-specific policies and procedures in accordance with current standards of care.	
	4. Interprets physical and psychosocial data.	
	Level 2	

	Pathophysiology	
	1. Outlines the pathophysiology of gestational diabetes and its relationship to the development of type 2 diabetes.	
	2. Describes the pathophysiologic basis of hypoglycemia, HHS, and DKA.	
	3. Identifies risk factors for hypoglycemia, HHS, and DKA.	
	Epidemiology of Prediabetes and Diabetes Disease State	
	1. Recognizes the effects of healthcare disparities on people with diabetes.	
	2. Recognizes population trends for at risk groups in your community.	
	Clinical Practice	
	1. Evaluates diabetes education, support, and care delivery according to current standards of care.	
	2. Develops or revises diabetes education and support policies and procedures according to standards of care.	
	3. Assesses current trends from diabetes research for application to practice.	
	4. Refers for clinical care outside the expertise of educator's discipline.	
	Level 3	
	Pathophysiology	
	1. Applies knowledge of diabetes pathophysiology to direct diabetes education and/or diabetes care.	
	Epidemiology of Prediabetes and Diabetes Disease State	
	1. Provides clinical expertise to others on the health care team.	
	2. Communicates population trends and health disparities to key stakeholders.	
	Clinical Practice	
	1. Applies best available evidence to assist in the review and/or the development of clinical practice guidelines.	
	2. Facilitates coordination and communication with healthcare team.	
	3. Serves as content expert for diabetes education and management.	
	4. Maintains and applies advanced clinical knowledge and skills appropriate to educator's scope of practice.	
	Domain 2: Cultural Competency Across the Lifespan Competency: Provides diabetes support and care in a culturally-competent manner across the lifespan.	
	Level 1	
	Cultural Competency	
	1. Understands definitions of race, ethnicity, and culture, including the culture of medicine.	
	2. Selects educational materials consistent with person's age, literacy and numeracy level, cultural or ethnic background, and physical or cognitive disabilities.	
	3. Uses culturally appropriate information to establish therapeutic relationship or uses pertinent cultural data in care of people with diabetes.	
	4. Recognizes cultural and socio-economic challenges in person's ability to self-manage their disease.	
	Lifespan	

	1. Provides evidenced-based diabetes education to persons across the lifespan.	
	2. Assesses support systems available to persons across the lifespand and/or for specific populations.	
	3. Develops community coalitions to meet needs across the lifespan.	
	Level 2	
	Cultural Competency	
	1. Facilitates problem solving in cultural and socio-economic challenges in patients.	
	2. Models culturally-competent behavior to healthcare team members.	
	3. Works with community groups to meet the needs of specific cultural populations and address barriers.	
	4. Recognizes that cultural issues affect health and healthcare quality and cost.	
	5. Recognizes own cultural sensitivity and humility.	
	6. Recognizes person/family-centered beliefs vs. health provider beliefs.	
	7. Understands work culture and issues.	
	8. Develops and evaluates the effectiveness of diabetes program to ensure health disparities are addressed.	
	Lifespan	
	1. Uses age appropriate theories for information, application, health, and chronic disease self-management education.	
	2. Assists people with diabetes to develop coping skills appropriate for chronologic and developmental age.	
	3. Assists other healthcare providers to develop and apply age-appropriate teaching strategies.	
	4. Identifies and assesses local and regional communitiies to establish effective support networks for people with diabetes.	
	5. Promotes safe transitions in the care of diabetes for person across the lifespan.	
	Level 3	
	Cultural Competency	
	1. Creates and disseminates educational programs and materials to address different cultural, physical, cognitive, literacy, and numeracy needs.	
	2. Works to eliminate healthcare disparities in vulnerable populations.	
	Lifespan	
	1. Assesses and establishes effective support networks in the local, state, and regional communities for person across the lifespan.	
	2. Individualizes management plans and education across the lifespan.	
	Domain 3: Teaching and Learning Skills Competency: Applies principles of teaching and learning and/or behavior change to facilitate self-management skills of individuals with diabetes. Pursues ongoing professional development.	
	Level 1	

	Teaching and Learning	
	1. Applies health behavior and education theory to inform, motivate, and support person throughout the lifespan.	
	2. Teaches, reinforces, and validates diabetes elf-management skills, including survival skills.	
	3. Assesses person's skills and knowledge level, education, and support needs.	
	4. Assesses health literacy, readiness to learn, preferred learning style and barriers to learning.	
	5. Collaborates with person with diabetes and healthcare team to problem solve difficulties in attainment of behavior goals.	
	6. Works with person to develop a personalized follow-up plan for ongoing self-management support.	
	7. Communicates person with diabetes outcomes, goals and plan for ongoing self-management support to other members of the healthcare team.	
	8. Plans and implements diabetes self-management education and support.	
	Behavior Change/Support	
	1. Facilitates problem-solving to overcome barriers.	
	2. Applies basic motivational interviewing skills to assist person with diabetes in appropriate and measureable goal setting (i.e., implements behavioral goal plan for person).	
	3. Helps patients use shared decision-making tools to promote behavior change.	
	4. Demonstrates respect for choices made by person with diabetes.	
	5. Develops an individualized support plan in collaboration with person with diabetes.	
	6. Communicates progress with healthcare team.	
	Professional Development	
	1. Applies current evidence-based theory, practice, and standards of care.	
	2. Maintains diabetes/diabetes-related continuing education (CE) credits per discipline.	
	3. Complies with professional, ethical, laws, regulations, and policies according to professional practice.	
	4. Recognizes and practices within own areas of skill and expertise.	
	5. Employs current computer/health information technologies and digital and mobile technology skills.	
	Level 2	
	Teaching and Learning	
	1. Facilitates an individualized education plan that is focused on behavior change.	
	2. Applies knowledge of age-specific learning principles, health literacy, and behavior change theory to develop effective diabetes self-management education and support (DSMES) programs.	
	3. Serves as a resource in curriculum development and maintenance, program planning, implementation, and evaluation.	
	Behavior Change/Support	
	1. Utilizes motivational interviewing and other techniques to identify person with diabetes readiness to change, then develops strategies for change.	
	2. Applies shared decision-making to promote behavior change.	

	Professional Development	
	1. Critically appraises own knowledge, skills, and work practices and develops a professional development plan to address deficiencies.	
	2. Seeks feedback of own performance from peers and others in volved in diabetes care.	
	3. Reviews current peer-reviewed research literature on pathophsiology of prediabetes and diabetes.	
	4. Keeps current on diabetes and healthcare-related technologies/person-facing technologies (e.g., mobile apps for communicating with people with diabetes and for data collection and analysis, continuous glucose monitoring (CGM), pumps, and other wearable technologies).	
	5. Keeps current on regulatory and privacy issues associated with new healthcare technologies.	
	Level 3	
	Teaching and Learning	
	1. Supports the professional development of diabetes educators and other healthcare professionals.	
	2. Mentors new diabetes educators and diabetes paraprofessionals.	
	Behavior Change/Support	
	1. Fluidly shifts among behavioral approaches to meet evolving needs of person with diabetes.	
	2. Teaches behavioral theories and approaches to colleagues and other healthcare professionals.	
	Professional Development	
	1. Participates in professional organization workgroups/committee to promote filed of diabetes education.	
	2. Seeks advanced-level educational opportunities in diabetes education and mangement.	
	3. Develops and delivers diabetes education programs for healthcare providers and others.	
	4. Demonstrates a knowledge of ethical practice for conducting research.	
	5. Participates or collaborates in research.	
	6. Develops and conducts or participates in diabetes-related research activiteis according to educational preparation.	
	Domain 4: Self-Management Education Competency: Works with an interdisciplinary diabetes care team to tailor interventions to individual self-management education needs.	
	Level 1	
	Healthy Eating	
	1. Reviews meal plan and eating habits. Refers to RD/RDN for MNT as appropriate.	
	2. Teach and reinforces principles of healthy eating.	
	3. Teaches how to read food labels.	
	4. Teaches basic principles of carb counting.	
	Being Active	

	1. Verifies medical clearances for exercise program and refers to healthcare team members as needed.	
	2. Provides guidelines for a safe activity plan.	
	Monitoring	
	1. Demonstrates correct technique for blood glucose and ketone monitoring.	
	2. Discusses benefits of monitoring.	
	Taking Medications	
	1. Identifies and explains the differences between prescribed oral and injectable medications for diabetes and co-morbid conditions.	
	2. Discusses safe use and common side effects of prescribed diabetes medications.	
	3. Teaches staff and patients on safe preparation, storage, administration of injectable medications and disposal of syringes and lancets.	
	Problem Solving	
	1. Reviews and updates local community resources list to keep current.	
	2. Provides instruction on hypoglycemia and hyperglycemia prevention, detection, and treatment.	
	3. Provides guidelines for sick day management, lab, or diagnositc testing, surgery and faith-based customs.	
	4. Collaborates with person with diabetes to deveop plan for when to contact diabetes healthcare provider.	
	5. Collaborates with person with diabetes to develop travel and disaster plans.	
	6. Discusses actual or potential barriers to self-management care.	
	Healthy Coping	
	1. Distinguishes between physical and emotional effects of blood glucose level variability.	
	2. Recognizes need for appropriate referrals to behavioral health resources as identified.	
	3. Identifies resources of support and resources to assist with healthy coping.	
	Reducing Risks	
	1. Discusses modifiable and non-modifiable risk factors for diabetes and associated complications.	
	2. Provides information on risk reduction strategies and diabetes standards of care.	
	Level 2	
	Healthy Eating	
	1. Reviews and discusses body mass index (BMI), weight trend, and food log in personal health record.	
	2. Teaches advanced concepts of carbohdyrate counting and meal-based insulin dosing as appropriate.	
	3. Explains the relationship between food, activity, medication, and blood glucose in preventing hypoglycemia and hyperglycemia.	
	4. Evaluates nutrition-related lab values and refers to RD/RDN as appropriate.	
	Being Active	
	1. Explains the relationship between physical activity and blood glucose.	
	2. Collaborates with person to develop a safe and effective activity plan.	

	3. Assess effectiveness of individual activity plan/action plan/goal.	
	Monitoring	
	1. Identifies appropriate meters for person with special needs.	
	2. Serves as local resource on monitoring-related issues.	
	3. Teaches and reinforces safe and accurate blood glucose monitoring.	
	4. Works with person with diabetes and diabetes care team to develop appropriate monitoring schedule.	
	5. Teaches person with diabetes to use results of A1C and blood glucose patterns to make informed decisions on diabetes self-management.	
	6. Introduces and discusses pattern management, continuous glucose monitoring (CGM), and insulin pumps as appropriate.	
	7. Teaches and reinforces safe and appropriate use for CGM and insulin pumps.	
	Taking Medications	
	1. Discusses use of over the counter (OTC) medications, supplements, and complementary alternative medicine (CAM) and possible effects on glucose levels.	
	2. Works with person with diabetes and healthcare team to individualize the diabetes medication plan.	
	3. Supports person with diabetes as they consider, initiate, and learn how to use an insulin pump.	
	4. Coordinates the plan of care between the prescriber, insulin pump manufacturer, and inulin pump trainer during pump initiationa nd ongoing management.	
	5. Obtains certification to provide training in the use of each specific brand and model of insulin pump with which they work.	
	Problem Solving	
	1. Evaluates local community resources that support everyday living needs for person with diabetes.	
	2. Facilitates problem solving/brain-storming techniques to help person with diabetes identify solutions to barriers in their self-management.	
	3. Implements shared decision-making in order to engage the person in the treatment plan.	
	Healthy Coping	
	1. Distinguishes signs and symptoms of depression and diabetes distress.	
	2. Identifies risk factors for depression and refers to appropriate team member.	
	3. Provides ongoing support for person and encourages them to make use of available resources.	
	Reducing Risks	
	1. Assists the person with diabetes to implement and sustain a diabetes self-management education and support (DSMES) plan for optimal health outcomes.	
	2. Strategizes with person with diabetes to develop a risk reduction plan.	
	3. Identifies eating disorders and other psycho-social risks and refers to behavioral health professional.	
	4. Identifies signs and symptoms of mild cognitive impairment (MCI) and refers to healthcare team.	

	5. Facilitates training of DSMES program staff and primary care provider (PCP) offices on annual chart reviews to assure standards of care in diabetes prevention (labs, test, etc.) are being ordered and reviewed with person with diabetes.	
	Level 3	
	Healthy Eating	
	1. Uses comprehensive knowledge of nutrition and diabetes meal planning to provide or support MNT to/for person with complex needs.	
	2. Assess person's ability to manage blood glucsoe with carb counting, continuous glucose monitoring (CGM), and/or insulin pumps.	
	3. Assesses adequacy of daily nutiriton intake and refers to RD/RDN as needed.	
	4. Assists endurance/competitive athletes with meal planning for trainin and competition, or refers if appropriate.	
	Being Active	
	1. Develops an activity plan that accomodates variation in routine and endurance.	
	2. Works with endurance/competitive athletes to develop a safe and effective diabetes self-management plan.	
	3. Assess and reassess patient progress and ability to maintain their individualized activity plan.	
	Monitoring	
	1. Evaluates continuous glucose monitoring (CGM) records to achieve and maintain goals in high-risk person.	
	2. Works with endurance/competitive athletes to determine effective monitoring plan for training and competitions.	
	3. Develops algorithm or protocol-based medication adjustments for changes in meal plan or exercise.	
	4. Assesses person's ability and appropriateness to use CGM.	
	5. Serves as a resource for other healthcare professionals and community orgaizations that provide support for individuals who use insulin pumps and to family members or others who support the person with diabetes.	
	6. Assists person with diabetes with advanced pattern management skills.	
	7. Instructs healthcare professionals in various levels of pattern management.	
	8. Conducts periodic assessments to evaluate changes in a person's clinical condition, motivation, abilities, and life circumstances that may necessitate the need to reconsider appropriateness of CGM use.	
	Taking Medications	
	1. Works with person with diabetes and diabetes care team to simplify medication plans and find lower medication cost opportunities, when need is identified.	
	2. Assesses for potential drug/drug or food/drug interactions and refers to pharmacist or registered dietitian/registered dietitian nutritionist as appropriate.	
	3. Periodically assesses for changes in person's clinical condition, motivation, abilities, and life circumstances that may necessitate the need to reconsider approriateness of insulin pump therapy.	
	4. Makes medication changes or follows medication adjustment protocols, or makes necessary recommendation to primary care provider.	
	Problem Solving	

	1. Identifies changes in medical/mental/physical status that affect the person with diabetes ability to follow medical treatment plan and refers to appropriate team member.	
	Healthy Coping	
	1. Assesses person with diabetes use of available resources and need for additional support.	
	2. Probes for emotional and/or physical factors linked to depression and treats/refers as appropriate.	
	3. Assesses for mild cognitive impairment (MCI) and makes appropriate referrals for follow-up care/counseling.	
	4. Assesses for diabetes distress and works with person with diabetes to address areas that are causing stress.	
	5. Provides or refers to behavioral health professional for support of diabetes-related distress and depression.	
	Reducing Risks	
	1. Facilitates coordination of care across specialty care, facility-based care, and community organizations.	
	2. Facillitates the development of personal strategies to accomodate sensory or physical limitation(s), adapting to new self-management demands, and to promote behavior change.	
	3. Facilitates training of diabetes self-management education and support (DSMES) program staff and primary care provider (PCP) offices on how to interpret annual labs/testing to assess current status of disease progression and needs for additional medical/psycho-social interventions.	
	Domain 5: Program and Business Management Competency: Applies principles of program and/or business management to create a climate that supports successful self-management of diabetes.	
	Level 1	
	Program Management	
	1. Plans for follow-up and intiates referrals to secure appropriate services for person with diabetes and family.	
	2. Provides diabetes self-management education and support (DSMES) referral feedback report on individual clients to the appropriate PCP referral office.	
	3. Follows the National Standards for Diabetes Self-Management Education and Support and complies with program accreditation/recognition requirements.	
	Business Management	
	1. Adheres to professional documentation protocol, HIPAA, medical records release at both the organizational and program levels.	
	2. Provides updated license, registration, certification documents to support diabetes education program accreditation/recognition.	
	3. Communicates activities and outcomes of service through designated channels to the employer and other as appropriate.	
	4. Assists with monitoring and evaluating outcomes of education.	
	5. Uses appropriate billing codes for services provided.	
	6. Follows designated lines of communication per organization.	

	7. Conducts community screening events.	
	Level 2	
	Program Management	
	1. Uses evidence to guide the delivery of diabetes care and education.	
	2. Directs and/or manages all aspects of a diabetes education program.	
	3. Incorporates strategies to integrate diabetes self-management education and support (DSMES) program into patient-centered medical home (PCMH) model of care.	
	4. Reviews program edcuational material/resources and communication pieces to assure they meet current community/cultural needs for DSMES program population.	
	5. Provides coaching and/or mentorship to other memebers of the diabetes care team.	
	6. Oversees program accreditation/recognition requirements.	
	7. Develops plan for recuitment and retention of class participants.	
	8. Provides education to healthcare providers, clinical groups, professionals, paraprofessionals, and the public at large.	
	9. Monitors achievement of person with diabetes self-management goals and other outcome(s) as a way to evaluate the effectiveness of the educational intervention(s), using appropriate measurement techniques.	
	10. Reports program evaluation results for administrative support and fiscal stability.	
	11. Develops plan and markets DSMES program(s) diabetes education program(s) to key stakeholders.	
	12. Develops plan for recruitment and retention of class participants.	
	13. Conducts yeasly competitite analysis of area DSMES programs to determine most appropriate mix of program services for own program.	
	14. Supports diabetes coalition building to provide more access and resources for people with diabetes.	
	15. Implements and evaluates program using continuous quality improvement CQI methods.	
	Business Management	
	1. Demonstrates knowledge of sound business practices for diabetes self-management education and support (DSMES) program planning, implementation and evaluation.	
	2. Identifies system failures/inefficiences and develops plan of correction.	
	3. Uses principes of continuous quality improvement (CQI) to seek opportunities to improve quality and efficiency of program services. Conducts CQI strategies per organizational and prgram identified nees and policies.	
	4. Demonstrates skills in team building, communication and conflict management.	
	5. Balances competing demands on time and financial resources.	
	6. Serves as a role model of leadership, effective communication, and collaboration to the interdisciplinary/multi-professional care team.	
	7. Reviews program financial revenue and line item reports, identifies discrepancies, issues and communicates with financial services department or equivalent.	
	Level 3	

	Program Management	
	1. Develops and evaluates program management competencies (e.g., problem-solving, interpersonal effectiveness, and organizational awareness among staff and healthcare providers in diabetes education program).	
	2. Promotes a culture of colegiality that enables members of the multidisciplinary team to feel respected and valued.	
	3. Designs innovative strategies to improve program effectiveness and enhance care continuity.	
	4. Analyzes the current system. Recognizes system failures and develops strategies for improvement.	
	5. Works toward improving population-based interventions.	
	5. Mentors other members of the diabetes care team.	
	7. Serves as consultant for the development, assessment of program evaluation, and documentation.	
	Business Management	
	1. Facilitates leadership practice and team building.	
	2. Uses basic knowledge of business management to plan, develop, and execute successful programming.	
	3. Uses principles of human resource development and planning to create and effectively manage groups of people.	
	4. Represents the diabetes service on relevant committees.	
	5. Communicates with other healthcare professionals in integrated diabetes services across the diabetes care continuum.	
	6. Annually reviews business management and current best practices.	
	7. Disseminates accurate information about the function and role of the diabetes educator and the service to consumers, other health professionals, and the wider community as appropriate.	
	8. Advocates the value of diabetes education acrossthe continuum of healthcare and community services.	
	9. Communicates about billing and reimbursement issues with departments of financial services and contracts or comparable departments.	
	10. Advocates for diabetes eduation funding and support.	
	11. Facilitates/participates in regional/state community assessment plans as related to access in diabetes education, management and services.	

Signature: _____ **Date:** _____

Supervisor Signature: _____ **Date:** _____