Competencies for the Diabetes Community Care Coordinator

Domain 1: Support of Clinical Management Practice and Integration	
The diabetes community care coordinator maintains the necessary knowledge and skills in diabetes to provide support in the management of diabetes and cardiometabolic conditions.	
1. Support of Clinical Management of Diabetes and Cardiometabolic Conditions	
1.1.1	Describes differences between prediabetes, type 1 and type 2 diabetes, and gestational diabetes
1.1.2	Describes the relationship between diabetes and cardiometabolic conditions
1.1.3	Lists risk factors for developing type 2 diabetes and related conditions
1.1.4	Reviews common acute complications of diabetes
1.1.5	Provides person-centered support and education for self-care to individuals and their caregivers
1.1.6	Identifies Social Determinants of Health (SDOH) and the resulting gaps in resources and support for self-care
1.1.7	Collects diabetes information which may include glucose meter or continuous glucose monitoring (CGM) logs from health information technology sources
1.1.8	Collaborates and participates in ongoing communications with primary care providers
1.1.9	Demonstrates understanding of the relevant scope of practice of interprofessional care team including roles and responsibilities
2. Support of Clinical Practice: Healthy Coping	
1.2.1	Demonstrates awareness of psychosocial and emotional health within the daily self-management of diabetes
1.2.2	Provides examples of healthy coping strategies to incorporate into daily activities
1.2.3	Assists individuals with recognition of barriers and facilitators related to self-care to support positive change
1.2.4	Uses screening tools as indicated to identify concerns with healthy coping, such as diabetes distress, depression, eating disorders, and other mental health concerns
1.2.5	Assists individuals with appointments to behavioral specialists and supports ongoing participation in care
3. Support of Clinical Practice: Reducing Risks	
1.3.1	States complications of and risk factors for diabetes
1.3.2	Explains healthy behaviors to help prevent type 2 diabetes and/or reduce risks of related complications
1.3.3	Outlines key prevention behaviors to maintain health at points of care transitions (at diagnosis, annually and/or when not meeting treatment targets, when complicating factors develop, and when transitions in-life and care occur)
1.3.4	Matches potential barriers to healthy behavior with steps to maintain or improve health and prevent complications
4. Support of Clinical Practice: Taking Medication	
1.4.1	Reviews medication plan with individual and confirms understanding
1.4.2	Assists individuals with recognition of barriers and explains strategies for uninterrupted medication use
1.4.3	Identifies and communicates issues that require care team intervention

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5. Support of Clinical Practice: Healthy Eating	
1.5.1	Describes general considerations for healthy eating, such as food groups, label reading, portion sizes, and meal planning
1.5.2	Explains components of healthy eating patterns, such as including non-starchy vegetables, minimizing added sugars and refined grains, and choosing whole foods instead of processed foods
1.5.3	Assists individuals to incorporate cultural and socioeconomic preferences into meal planning and eating patterns
1.5.4	Assists individuals with recognition of barriers and implementation of strategies for healthy eating
1.5.5	Uses knowledge of the interaction between food, activity, and medication to promote and maintain healthy eating choices
6. Support of Clinical Practice: Monitoring	
1.6.1	Explains available tools used for monitoring, such as meters for glucose monitoring, devices for continuous glucose monitoring (CGM), mobile applications (apps), and point of care (POC) tools
1.6.2	Assists in the training needed for glucose monitoring and (when necessary) urine ketones
1.6.3	Assists individuals with recognition of barriers to effective monitoring and explores possible solutions for overcoming barriers with self-monitoring
1.6.4	Supports individuals' attempts to achieve and maintain effective self-monitoring habits
7. Support of Clinical Practice: Being Active	
1.7.1	Understands the role and impact of physical activity and fitness in prevention and treatment of diabetes and cardiometabolic conditions
1.7.2	Encourages physical activities as recommended by the care team
1.7.3	Assists individuals to overcome barriers to routine physical activity and connects them with appropriate community resources
1.7.4	Supports individuals as they make changes in movement patterns appropriate for age and life stage and refers to health care team for modifications
8. Support of Clinical Practice: Problem Solving	
1.8.1	Works with individuals to identify solutions to challenges with self-management
1.8.2	Demonstrates use of tools including adaptive aids to facilitate effective self-management
1.8.3	Assists individuals with goal setting
1.8.4	Adapts education tools to support literacy
1.8.5	Supports individuals to integrate established plan of care into daily lives

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