Competencies for the Health Professional Where Diabetes is Not the Primary Focus

Member of the diabetes care team who interact with people with diabetes and related conditions, but whose primary focus is not diabetes. This includes, but is not limited to, registered nurses (RN), registered dietitian nutritionists (RDN), pharmacists, and other similar roles.

Domain 1: Clinical Management Practice and Integration

Health professionals maintain knowledge and skills in pathophysiology, epidemiology, clinical management, and self-management to support people with diabetes and cardiometabolic conditions.

1. Clinical Management of Diabetes and Cardiometabolic Conditions	
1.1.1	Describes the difference between prediabetes, type 1 and type 2 diabetes, and gestational diabetes
1.1.2	States the diagnostic criteria, risk factors, and progression of diabetes across the life span
1.1.3	Identifies the impact of glucose levels on the development of diabetes and cardiometabolic conditions
1.1.4	Recognizes the signs and symptoms of hypoglycemia, hyperglycemia, hyperosmolar hyperglycemic state (HHS), and diabetes-related ketoacidosis (DKA)
1.1.5	Applies knowledge of the pathophysiology of diabetes and cardiometabolic conditions to provide diabetes care
1.1.6	Applies clinical practice guidelines into care and care models
1.1.7	Refers or facilitates referrals and/or treatments as appropriate
1.18	Assesses Social Determinants of Health (SDOH) and identifies the gaps in resources and support for self-care
1.1.9	Recommends and provides interventions as appropriate for community-based resources to support self-care
1.1.10	Provides person-centered care, education and support for diabetes self-care
2. Clinical Practice: Healthy Coping	
1.2.1	Assists individuals with identifying and prioritizing their goals as part of the shared decision making process
1.2.2	Identifies the impact of psychosocial and emotional health within the daily self-management of diabetes
1.2.3	Assesses impact of individual's behavioral and emotional health on the plan of care
1.2.4	Assists individuals with recognition of barriers and implementation of strategies for healthy coping
1.2.5	Screens for the presence of diabetes distress, depression, eating disorders, and other mental health concerns
1.2.6	Appropriately refers individuals to behavioral specialists or community behavioral resources
1.2.7	Facilitates the development of healthy coping skills in people with diabetes and cardiometabolic conditions
3. Clinical Practice: Reducing Risks	
1.3.1	Encourages participation in diabetes self-management education and support (DSMES), the National Diabetes Prevention Program (DPP), medical nutrition therapy (MNT), and other individual or group models of care
1.3.2	Provides or facilitates referrals to diabetes care and education specialists, which may include registered dietitian nutritionists (RDN), certified diabetes care and education specialists (CDCES), and those with the credential, board certified-advanced diabetes management (BC-ADM)
1.3.2	Applies knowledge of diabetes-related complications and associated risk factors for education, prevention, and management
1.3.3	Implements risk reduction strategies to minimize actual and potential risks related to common diabetes-related complications

1.3.4	Implements prevention strategies to assist individuals with diabetes and cardiometabolic conditions at care transition points (at diagnosis, annually and/or when not meeting treatment targets, when complicating factors develop, and when transitions in-life and care occur)
1.3.5	Assists individuals with recognition of barriers and implementation of strategies to effectively reduce the risk of diabetes and diabetes-related complications
1.3.6	Develops processes to ensure access to resources needed for self-management at the time of transition
1.3.7	Advocates for appropriate and timely adjustments in plans of care to prevent therapeutic inertia
4. Clinical Practice: Taking Medication	
1.4.1	Explains administration technique, dosing, frequency, side effects, storage, expiration, and benefits of medication taking
1.4.2	Identifies medications ordered for diabetes and cardiometabolic conditions
1.4.3	Identifies and communicates issues that require care team intervention
1.4.4	Assists individuals with recognition of barriers and co-develops strategies for uninterrupted medication use
1.4.5	Applies knowledge of the healthcare system and individual's medications to facilitate uninterrupted access to medications, devices, and supplies necessary to self-manage diabetes and cardiometabolic conditions
1.4.6	Demonstrates awareness of insulin pumps
5. Clinical Practice: Healthy Eating	
1.5.1	Facilitates referrals to National Diabetes Prevention Program (DPP), diabetes self-management education and support (DSMES) and medical nutrition therapy (MNT) providers, including diabetes care and education specialists and registered dietitian nutritionists
1.5.2	Applies nutrition knowledge, cultural and socioeconomic considerations, and person's preferences to assess and individualize healthy meal plans
1.5.3	Connects person with recommended online resources to support healthy behaviors to maintain healthy eating patterns
1.5.4	Describes general components of healthy eating, such as food sources of macronutrients, label reading, portion sizes, and meal planning
1.5.5	Explains relationship between food, activity, medication, and clinical outcomes, such as blood glucose, lipids, blood pressure, and weight
1.5.6	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
1.5.7	Compares and contrasts various eating patterns useful for the management of diabetes and cardiometabolic conditions
1.5.8	Assists individuals with recognition of barriers and implementation of strategies for healthy eating
6. 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	Supports the individual's attempts to achieve and maintain effective self-monitoring habits
1.6.3	Applies knowledge of monitoring to provide guidance on achievement of treatment goals
1.6.4	Assists individuals with recognition of barriers and implementation of strategies for effective monitoring

7. 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	Applies knowledge of exercise related glucose excursions to provide recommendations for aerobic, resistance, and other physical activity
1.7.3	Assists individuals with recognition of barriers and implementation of strategies to promote physical activity
1.7.4	Selects recommendations for physical activity based on factors such as pregnancy, age, body mass index, weight management goals, and macrovascular and microvascular complications
8. Clinical Practice: Problem Solving	
1.8.1	Employs collaborative problem-solving methods to identify and resolve gaps in the plan of care
1.8.2	Utilizes knowledge of problem solving and goal setting to develop appropriate and realistic plans of care
1.8.3	Develops person-centered plan of care consistent with available support systems, and physical, developmental, and cognitive levels
1.8.4	Assists individuals with recognition of barriers and implements strategies for effective problem solving