Vermont's State Strategy

Increasing availability of and access to ***diabetes self-management education and support*** *services*

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Contents

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Introduction

Diabetes self-management education and support services, commonly known as DSMES, offers people with diabetes comprehensive diabetes education to develop the knowledge and skills needed to effectively manage diabetes. DSMES is delivered by a certified diabetes care and education specialist or another qualified health care professional who can provide a foundation for confident self-care.

DSMES programs can be accredited by the Association of Diabetes Care and Education Specialists (ADCES) or recognized by The American Diabetes Association (ADA). Accreditation and recognition are distinctions that ensure that a DSMES program meets strict national criteria for diabetes care. There is little difference between the two, and a complete description of each can be found in Strategy Theme #2.

With the support of the Centers for Disease Control and Prevention, the Vermont Department of Health (VDH) has collaborated with around 75 partners from across the State, to develop this state strategy to equitably expand DSMES services, making them available to more Vermont residents.

As of January 2025, Vermont has seven ADCES accredited organizations offering DSMES and three ADA recognized organizations. You can visit the VDH DSMES Site Locator Map for regularly updated site information. Despite the efforts of currently accredited and recognized organizations, DSMES remains inaccessible to many Vermont residents. VDH hopes to double the number of DSMES sites by July 2028 and to help ensure that sites are inclusive and accessible.

This guide is designed to clarify the DSMES accreditation and recognition processes for health care and community organizations, offer support in planning and implementing DSMES, and help organizations prioritize accessibility, equity, and inclusion in their efforts to help the people of Vermont better manage diabetes.

Please use this guide however it works for you. Follow along from start to finish or choose just a few resources. For example, if you're new to the concept of DSMES, and you're not sure if it's right for your practice or organization, consider starting with Strategy Theme #1, but if you know you want to offer recognized or accredited DSMES at your practice or organization, but you're feeling overwhelmed and not sure where to begin, Strategy Theme #2 is a good place to start.

If you need help accessing or understanding this information, contact AHS.VDHHPDPDSMES@Vermont.gov.

What acronyms and definitions will be helpful to know as I explore?

Acronyms with Definitions:

1. DSMES: Diabetes Self-Management Education and Support (DSMES) services provide information and skills for people to manage their diabetes and related conditions. DSMES is tailored to meet individual needs, goals, and life experiences and is guided by evidence-based standards. DSMES is led by a health professional like a registered nurse, registered dietitian, or pharmacist who has received special training in diabetes care and education. There are key times when a provider can refer to DSMES: at the initial diagnosis, annual health care visits, if health complications arise, and when changes in care needs or other life changes make diabetes management harder. Accredited or recognized DSMES programs must offer a diabetes self-management education component. A Diabetes Self-Management Program, like My Healthy VT (MHVT), can provide that component.
2. DSMP: A Diabetes Self-Management Program (DSMP) is a structured educational program designed to help people with diabetes manage their condition effectively. These programs aim to empower participants with the knowledge, skills, and confidence needed to take control of their diabetes and improve their overall health outcomes. DSMPs can be delivered in various formats, including in-person workshops, online courses, or one-on-one sessions with health care providers. The MHVT interactive workshop meets for 2.5 hours a week in various community locations or online. It is delivered by two trained leaders, one or both of whom have diabetes. MHVT DSMP workshops are free of charge for all people with diabetes who receive primary care in Vermont, and their caregivers.
3. DSME: Diabetes Self-Management Education (DSME) is a process that facilitates the knowledge, skills, and ability necessary for diabetes self-care. It is a critical component of diabetes management and aims to empower people with diabetes to take an active role in managing their condition. DSME is typically provided by health care professionals, such as certified diabetes educators, nurses, dietitians, or pharmacists, and can be delivered in various settings, including hospitals, clinics, community centers, or online platforms.
4. DSMT: The term Diabetes Self-Management Training (DSMT) refers specifically to billing for services. The Centers for Medicare & Medicaid Services uses the term "training" instead of "education and support" (DSMES) when defining the reimbursable benefit. To qualify for DSMT coverage, a participant must have a documented diagnosis of type 1, type 2, or gestational diabetes and meet the specific criteria.
5. MHVT: My Healthy VT (MHVT) is a series of free workshops to help Vermonters prevent and manage chronic conditions like type 2 diabetes. Each workshop is backed by science and led by trained facilitators who understand, often firsthand, the needs and struggles of Vermonters living with these conditions. Workshops are available in person or online in a small group setting and are designed to help participants make small changes to their day-to-day lives. MHVT is a collaboration between Blueprint for Health and the Vermont Department of Health.

Strategy Theme #1: Provider and Organizational Buy-In

The list of reasons to offer diabetes self-management and education services (DSMES) for patients is long. In this section, you'll review several high-level reasons before looking at the picture of diabetes in Vermont and what DSMES can offer Vermont's residents. Next, you'll become familiar with some of the basic terminology and components of DSMES. Finally, you'll find some resources that you can take or leave as you continue to explore the option to offer accredited or recognized DSMES at your health care practice or organization.

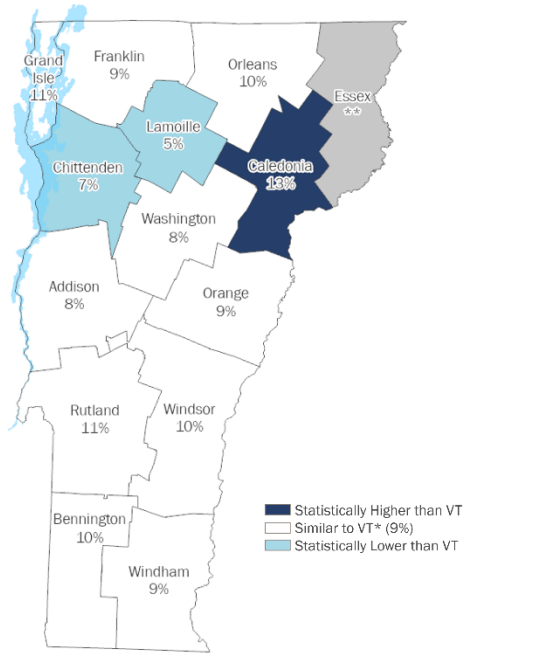
Why would a provider or organization want to offer ADA recognized or ADCES accredited DSMES services?

6. Improved Patient Outcomes and Quality of Life: DSMES empowers patients with the knowledge and skills necessary to manage their diabetes effectively. This can lead to better glycemic control, reduced risk of complications, and overall improved health outcomes.
7. Patient Empowerment: DSMES helps patients become active participants in their own care. They learn how to make informed decisions about their lifestyle, diet, medication, and monitoring, which can enhance their confidence and autonomy.
8. Prevention of Complications: DSMES can prevent or delay health complications such as cardiovascular disease, neuropathy, nephropathy, and retinopathy by helping patients understand the importance of regular monitoring and the benefits of treatment plans.
9. Cost-Effectiveness: DSMES leads to more effective self-management which can reduce the need for emergency care and hospitalization, which can be costly. DSMES can lead to more efficient use of health care resources and lower overall health care costs.
10. Personalized Care: DSMES offers health care providers opportunities to tailor management plans to the individual needs of each patient, considering factors such as age, lifestyle, comorbidities, and personal preferences.

Overall, diabetes self-management and education services are a critical component of comprehensive diabetes care, benefiting both patients and health care systems.

Diabetes Data in Vermont

Diabetes Prevalence by County



*Vermont estimate represents two years of data.
**Value suppressed because sample size is too small or relative standard error (RSE) is >30. Statistical comparisons are not completed on suppressed values.

Nine percent of Vermont adults have ever been diagnosed with diabetes. This is statistically lower than the 12% among U.S. adults. Diabetes is statistically more prevalent among certain groups of people in Vermont:

-The prevalence of diabetes statistically increases with age

-Diabetes rates are higher among adults with less education and lower household income

-Adults who are heterosexual and cis gender are statistically more likely to have diabetes

-Adults with a disability are more than two times as likely to report having diabetes than those with no disability.

-Adults who are military veterans.

For a more in-depth look at diabetes in Vermont, visit the Vermont Department of Health Diabetes Data Pages

- The prevalence of diabetes is significantly higher in Caledonia County and the Rutland and St. Johnsbury Health Districts when compared to the state average.
- Diabetes prevalence is significantly lower than the statewide average in Chittenden and Lamoille Counties as well as the Morrisville Health District.

Provider Management of Diabetes

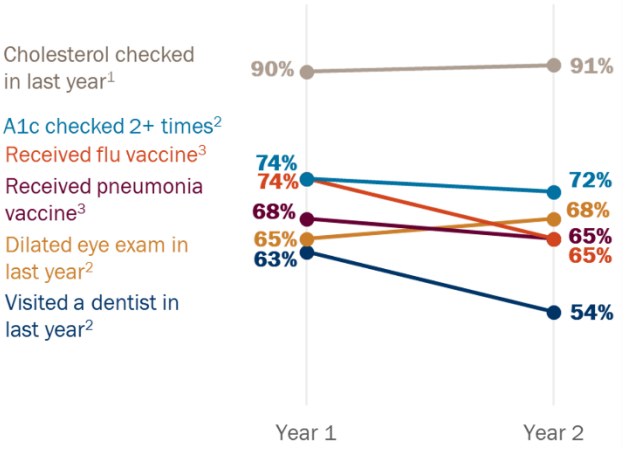
Among Vermont adults with diabetes who have seen a health care provider in the last two years:

-Hemoglobin A1c checks at least twice a year trended down in recent years from 74% to 72%, annual influenza vaccinations trended down from 74% to 65%, and pneumonia vaccinations from 68% to 65%.

-Cholesterol screening in the last year trended upward from 90% to 91% and annual dilated eye exams trended upward from 65% to 68%.

-Visits to an oral health care provider in the last year also trended downward in recent years from 63% to 54%.

The majority of provider-led diabetes management strategies trended downward in the two most recent measurement years.



Source: VT BRFSS, 2021 & 2023[1]; 2020 & 2022[2]; 2022 & 2023[3].
All data except dental visits are among those who have seen a health care provider in the past 2 years.
Differences between years shown are not statistically significant.

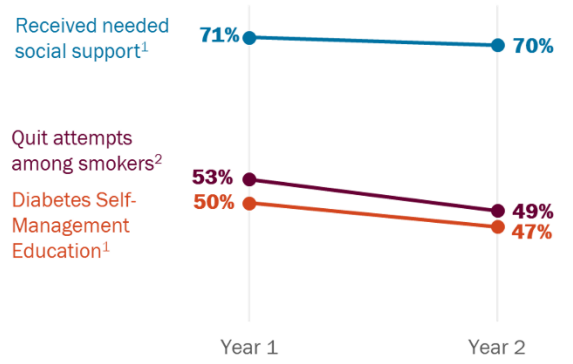
Adult Self-Management of Diabetes

-Nearly half (49%) of adults diagnosed with diabetes who smoked cigarettes in 2023 attempted to quit, trending down from the 53% who did in 2022.

-Less than half (47%) of adults diagnosed with diabetes in 2022 had ever attended diabetes self-management education, a decrease from the 50% who ever had in 2020. This remains below the Healthy Vermonters 2030 target of 57%.

-Seven in ten (70%) adults with diabetes felt they had received the social support they needed in 2022, similar to the 71% who had in 2020.

Diabetes self-management education, attempts to quit smoking, and having received needed social support trended downward among Vermont adults with diabetes.



Source: VT BRFSS, 2020 & 2022[1]; 2022 & 2023[2].
Differences between years shown are not statistically significant.
This is a Healthy Vermonters 2030 measure. See the HV2030 Performance Scorecard for additional details.

Where in Vermont are DSMES services currently located?

11. This Vermont DSMES site-locator (scroll down the page) shows the location of current accredited or recognized programs in an interactive GIS-map.
12. My Healthy Vermont (MHVT) offers diabetes self-management programs (DSMP) free of charge to any person with diabetes who receives primary care in Vermont. MHVT is available statewide.
13. MHVT is not the same as DSMES, but it can serve as the education component, to lessen the responsibility on the DSMES provider (more on that in Theme 6).

What is the return on investment for DSMES?

14. Strategy Theme #3 focuses on financial transparency and the provider/organization cost vs. benefit of offering DSMES. In brief:
15. Nationally, diabetes affects around 1 in 10 Americans and costs the nation an estimated $413 billion each year. Medical costs for people with diabetes are approximately 2.6 times higher than medical costs for people without diabetes. Diabetes-related costs are expected to increase as diabetes rates continue to climb. DSMES services improve health outcomes for people with diabetes, reducing hospital visits and saving money.
16. Studies indicate that DSMES services are both clinically beneficial and cost effective, especially when people attend more than one session. One study found that at least one DSMES visit lowered the hospitalization rate for people with diabetes by 34%.
17. Employers and insurers benefit from DSMES through improved employee productivity and reduced health care costs. A cost analysis of disease management services combined with diabetes education reported a return on investment of more than 4 to 1.
18. For more detailed information on the economic cost of diabetes and Vermont-specific statistics, visit https://nccd.cdc.gov/toolkit/diabetesburden
19. DSMES supports improved diabetes control through:
20. Reduced onset or progression of diabetes complications.
21. Improved quality of life
22. Long-term lifestyle change
23. Enhanced self-efficacy and empowerment
24. Improved coping
25. Decreased diabetes-related depression
26. Numerous studies show that patients that receive DSMES that follows national standards (as accredited and recognized DSMES programming does), lower their Hemoglobin A1c by at least 0.6% and up to 1%, as much as many diabetes medications.

Who can provide DSMES?

Diabetes Self-Management Education and Support (DSMES) services can be provided by a variety of health care professionals who have specialized training and expertise in diabetes care. These professionals typically work as part of a multidisciplinary team to deliver comprehensive education and support to individuals with diabetes. Key providers of DSMES services include:

27. Certified Diabetes Care and Education Specialists (CDCES): These professionals have specialized training in diabetes management and education. They are often nurses, dietitians, pharmacists, or other health care professionals who have obtained certification in diabetes education.
28. Board Certified-Advanced Diabetes Management (BC-ADM): BC-ADMs hold an advanced certification in diabetes management, along with a professional license.
29. Registered Dietitians (RDs) or Registered Dietitian Nutritionists (RDNs): These professionals provide nutrition education and counseling, helping individuals with diabetes understand how to manage their condition through diet and meal planning.
30. Nurses: Nurses, particularly those with experience in endocrinology or diabetes care, can provide education on medication management, blood glucose monitoring, and lifestyle changes.
31. Pharmacists: Pharmacists can offer medication management education, including information on how to take diabetes medications correctly, potential side effects, and interactions with other medications.
32. Physicians and Endocrinologists: While they primarily focus on medical management, physicians and endocrinologists can also provide education and support as part of a comprehensive diabetes care plan.
33. Social Workers and Psychologists: These professionals can address the psychosocial aspects of living with diabetes, offering support for stress management, coping strategies, and behavioral changes.
34. Physical Therapists and Exercise Physiologists: They can provide guidance on incorporating physical activity into daily routines safely and effectively, which is an important component of diabetes management.

Being a Certified Diabetes Care and Education Specialist (CDCES) is not strictly required to provide DSMES services; however, CDCES professionals are often preferred for DSMES because they have met specific educational and experiential criteria and have passed a certification exam that demonstrates their proficiency in diabetes management.

DSMES services can be delivered in various settings, including hospitals, clinics, community health centers, pharmacies, and even through virtual platforms. The goal is to provide accessible, personalized education and support to help individuals with diabetes manage their condition effectively and improve their quality of life.

What additional resources are available to me as I continue to explore offering DSMES?

Specific, in-depth information on accreditation and recognition:

35. ADCES: Diabetes Education Accreditation Program- obtain diabetes education accreditation and receive reimbursement for diabetes self-management education and support.
36. ADA: Education Recognition Program (ERP)- provides the framework for effective delivery of quality diabetes self-management education and support (DSMES) through the National Standards of DSMES. If you are seeking reimbursement for DSMES, it is appropriate to apply for ADA ERP.

Vermont Department of Health Resources:

37. My Healthy Vermont: Diabetes self-management workshops that can provide the DSME portion of DSMES.
38. DSMES State Specialist: NACDD, in partnership with the Centers for Disease Control and Prevention (CDC) and other leaders in diabetes programming, developed and launched State Specialist workforce training and development programs for state diabetes staff. The training equips state diabetes staff to become specialists in providing technical assistance and support to program providers working to expand access to and participation in the National Diabetes Prevention Program (National DPP) lifestyle change program and diabetes self-management education and support service (DSMES).
39. To connect with a specialist, email: AHS.VDHHPDPDiabetesTeam@vermont.gov
40. Diabetes data, tools, and resources: Videos, printable resources, data briefs and more.

Centers for Disease Control and Prevention Resources:

41. DSMES Toolkit- a comprehensive resource for achieving success in delivering DSMES services.

For ready-to-use materials that can be used to apply for and maintain accreditation, please visit the VDH DSMES Support Page at More information on VDH support can also be found in Strategy Theme #6.

Strategy Theme #2: Simplifying the Path to DSMES Accreditation

Becoming an ADCES-accredited or ADA-recognized DSMES provider can feel daunting. Beyond determining capacity and logistics, there's new terminology to learn, standards to interpret, steps to complete, and many resources to navigate. This section focuses on simplicity—outlining only the required steps and the tools that make each one easier. For clarity, we focus on ADCES accreditation through the Diabetes Education Accreditation Program (DEAP), which is more commonly used in Vermont. If you choose to pursue ADA recognition instead, the process is similar, though the resource templates may differ. Some general differences between the two organizations include: ADCES Accreditation:

1. ADCES Accreditation:
    - **Organization**: The Association of Diabetes Care & Education Specialists (ADCES) offers accreditation.
    - **Focus**: It emphasizes a comprehensive approach to diabetes self-management education and support (DSMES).
    - **Standards**: The National Standards for Diabetes Self-Management Education and Support, which are periodically updated to reflect current best practices.
    - **Application Fee**: $1,100 for the first site, with additional branch locations costing $100 each.
    - **Flexibility**: ADCES often provides more flexibility in terms of program structure and delivery, allowing for a variety of educational settings and methods.

2. ADA Recognition:
    - **Organization**: The American Diabetes Association (ADA) provides recognition.
    - **Focus**: Like ADCES, it focuses on DSMES but is specifically aligned with ADA's guidelines and standards.
    - **Standards**: ADA recognition also adheres to the National Standards for Diabetes Self-Management Education and Support.
    - **Application Fee**: $1,100 for the main site, with a $100 fee for each additional site.
    - **Reputation**: ADA recognition may be more recognizable due to the organization's long-standing reputation in diabetes care and research.

Both programs aim to ensure high-quality diabetes education and support, but the choice between them may depend on your specific organizational goals, preferences for certain educational frameworks, or perceived value of affiliation with either ADCES or ADA. Additionally, you may prefer one over the other based on logistical considerations, such as the application process or ongoing support provided by the accrediting body (ADCES or ADA). In the remainder of this section, you will find simplified steps to achieving ADCES accreditation.

Simplified Steps to ADCES Accreditation

Part of the Vermont State Strategy to increase availability of Diabetes Self-Management and Support (DSMES)

Step 1

National Standard: *Support for DSMES Services*

What you need: A letter of support from an administrative level sponsor at your organization or practice.

Details: Letters can be provided by a CEO/president, director, quality manager, supervisor, etc. If you are applying for accreditation as a solo health care professional, the letter must come from a referring physician or other qualified health professional who will refer to your DSMES services. Letters must be dated within six months of initial and renewal DSMES applications.

Resources:
Sample Letter of Administrative Support

Step 2

National Standard: *Population and Service Assessment*

What you need: A description of your organization's diabetes demographics and other considerations such as Social Drivers of Health and other barriers that impact your target population.

Details: This information is available from a variety of sources, including but not limited to community needs assessments by local or state health departments, health system/organizations specific to the populations, and DSMES data.

Resources:
Find your Vermont Department of Health (VDH) Local Health Office
Diabetes population demographics by county (customizable for your organization's application)

Step 3

National Standard: *DSMES Team*

What you need: A team that includes a designated Quality Coordinator and at least one credentialed health professional (RDN, RN, Pharmacist, CDCES, BC-ADM, etc.).

Details: The application must include a description of the Quality Coordinator's role and responsibilities within and outside the DSMES team, attestation that at least one team member is a credentialed health professional with documentation of each license, registration or certification and evidence of at least 15 hours of diabetes-related continuing education for each team member who is not a CDCES or BC-ADM. Any additional DSMES

care team members (Diabetes Community Care Coordinators) must report to a credentialed team member and have training and/or experience that is relevant to their role on the team.

Resources:
Templates for attestation and job description (open this link and scroll to Standard 3)

Step 4

National Standard: *Delivery and Design of DSMES Services*

What you need: Evidence that the team has access to and is familiar with a published and up to date diabetes education curriculum that is applicable to the people you serve. You will need to attest that all team members have reviewed the curriculum for content and relevance for your program.

Details: The chosen DSMES curriculum must include the following core content areas, and content must be prioritized to meet the individual PWD's current needs, abilities and goals:

- Pathophysiology of diabetes and treatment options
- Coping
- Nutritious eating
- Being active
- Taking medication
- Monitoring
- Reducing risk (treating acute and chronic complications)
- Problem solving and behavior change strategies

Resources:
DEAP pre-approved curricula:

42. ADCES Diabetes Education and Care Curriculum (E-Book $140 non-member/$112 member)
43. ADA Life with Diabetes (Book $99.95 member discounts available)
44. My Healthy Vermont (MHVT) uses the approved Self-Management Resource Center (SMRC)-licensed curriculum. Patients may be referred to MHVT for the curriculum portion of their DSMES services. For more information, please see Strategy Theme #6 or reach out to AHS.VDHHPDPMyHealthyVT@vermont.gov

Step 5

National Standard: *Person-Centered DSMES*

What you need: A description of how the assessment process (ongoing collaborative communication with the person with diabetes (PWD)) will be conducted and assurance that the communication is PWD-centered to best identify needs and agree on the PWD's preferred educational, coping, and behavioral interventions that will be used to develop needed problem solving, decision making, and self-management skills and strategies.

You also need to provide evidence of at least one DSMES intervention within the last 12 months as documented in the medical record (electronic health record (EHR), participant registry, paper chart, or other HIPAA compliant record that allows for collaboration across the care team).

Details: The record for the submitted example (and records for all DSMES participants once accredited) must include:

- DSMES Assessment
- DSMES Plan
- Each DSMES visit including date/time and topic areas covered with plan for follow-up
- Behavior Goal (ADCES7) and progress
- Outcomes of intervention communicated to referring physician/qualified health care professional

Resources:
ADCES7 Self-Care Behaviors
Sample documentation in "SOAP" format

Step 6

National Standard: *Measuring and Demonstrating Outcomes of DSMES Services*

What you need: A plan for collecting outcome data for evaluation and improvement of overall DSMES services and reporting to ADCES as part of Annual Status Report. DSMES teams must have a procedure in place to collect, combine, analyze, and demonstrate outcomes for participants seen as part of the DSMES services across all sites. A list of outcome examples is available in the resources below.

Details: Each year of accreditation, sites are required to engage in a basic continuous quality improvement (CQI) project that is designed to inform answers to the following questions:

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

One additional program level outcome must also be reported each year, and that measure CAN be part of the CQI project.

Resources:
Table of DSMES Outcome Examples (open link and scroll to last page of the document)

A simplified checklist of all accreditation requirements can be found on the VDH DSMES Support Page and as appendix X in this document.

Strategy Theme #3: Financial Transparency

For many health care practices/providers and organizations that are considering offering DSMES to their patients or participants, understanding the financial commitment is a key consideration. Strategy Theme #1 identified some long-term financial benefits such as reduced health care costs over time and reduced out of pocket expenses for people with diabetes, but for practices and organizations, the cost to sustainably run a DSMES program is undoubtedly top of mind. Providing DSMES is a labor of love and an investment. While some DSMES providers do earn profit, some may only break even or could incur losses, making this work challenging, but rewarding. Weighing financial expenses with the practice's or organization's goals, values, and budget are crucial. This section will explore the costs associated with offering DSMES programming and compare them with what you might expect to collect through insurance reimbursement.

Expenses:

Applying for and maintaining ADCES accreditation for Diabetes Self-Management Education and Support (DSMES) comes with several costs, both monetary and time/resource related.

- Application & Annual Fees
    - Initial Accreditation Application Fee (one-time fee for new applicants)
        - $1,100 (as of 2024) for the first site, and $100 for each additional site.
    - Annual Fee* (for reaccreditation/maintenance)
        - $1,100 per year
        - Required to maintain accredited status.
        - * ADCES may offer a discounted fee for sites with fewer than 50 patients participating in DSMES annually- this may reduce the annual fee.
- Staff Costs (Time & Training)
    - Time to develop and maintain the DSMES Program
        - Creating the program structure
        - Developing policies, procedures, and documentation
        - Collecting and evaluating outcomes data
- Training and CE for DSMES Team Members
    - Continuing education is required to maintain credentials and competencies.
    - Cost varies depending on courses, but budget $100–$500+ per person per year.
- Data Collection & Reporting
    - Outcome data tracking and evaluation must be performed regularly. This might require:
        - Staff time (internal)
        - Software or data management tools, if not already available (may range from free to $1,000+ annually)

- Audit Preparation & Quality Improvement
    - ADCES conducts audits every 4 years (random and scheduled). Time/resources needed to:
        - Prepare required documentation
        - Conduct internal quality improvement evaluations
        - No direct cost, but significant staff time investment.
- Supplies & Materials
    - Educational materials (print/digital handouts, visuals)
    - Cost varies widely; budget $100–$500/year
- Optional Costs
    - Approved DSME curriculum (if not using My Healthy VT)
        - ADCES Diabetes Care and Education Curriculum, 4th Edition (E-book)
            - $112 ADCES Member
            - $140 Nonmember
        - Other curriculum as approved
            - Cost varies
    - Consultation or Support Services
        - Hiring a consultant for preparing the application or quality improvement planning
            - Estimated: $500–$2,000, depending on scope
    - Technology or EHR Integration
        - If integrating DSMES into EHR or telehealth platforms
        - Costs depend on your current systems and needs

Summary:

Item	Cost Range
Annual Accreditation Fee	$1,100
Staff Time & Training	$500–$2,000+
Data Collection Tools	$0–$1,000
Materials	$100–$500
Optional Consultant Help	$0–$2,000 (one-time or as needed)

Typical total: $1,700–$4,500+ annually, depending on the size of your program and internal capacity.

Reimbursement for DSMES services:

Medicare and Vermont insurance providers (Medicaid, Blue Cross and Blue Shield of Vermont, MVP Health Care and Cigna) provide reimbursement for DSMES services. The information provided in this section is meant to offer general guidance. Insurance coverage may change and/or vary depending on updates to reimbursement rates and the type of service offered. To make sure you have the most accurate and up to date information, it is recommended that you:

1. Contact the insurer: Reach out directly to insurance companies, the Department of Vermont Health Access (DVHA), or the Centers for Medicaid and Medicare for detailed information on reimbursement rates.
2. Consult with providers: Health care providers who offer DSMES services and accept insurance may also have information on current reimbursement rates.
3. Review provider manuals: The insurer may publish provider manuals or fee schedules that outline reimbursement rates for various services, including DSMES.

The number of DSMES sessions that a provider can be reimbursed for typically depends on the specific policies of the payer, such as Medicaid, Medicare, or private insurance companies like MVP Health Care. Here are some general guidelines:

Medicare: Medicare Part B typically covers up to 10 hours of initial DSMES in the first year. This usually includes one hour of individual assessment and nine hours of group education. After the first year, Medicare may cover up to two hours of follow-up DSMES annually.

Medicare reimbursement rates for Diabetes Self-Management Education and Support (DSMES) can vary based on several factors, including geographic location and specific billing codes used. Per the latest information available, Medicare typically reimburses DSMES services under the Health Care Common Procedure Coding System (HCPCS) codes G0108 and G0109.

- G0108 is used for individual DSMES sessions, per 30 minutes.
- G0109 is used for group (2 or more patients) DSMES sessions, per 30 minutes.

For group sessions (G0109), Medicare reimbursement rates are generally lower per person compared to individual sessions. However, the exact reimbursement amount can vary, so it's important to check the current Medicare Physician Fee Schedule for the specific rates applicable to your location and circumstances.

Resource:
DSMES in the Medicare Physician Fee Schedule

Health care providers can also contact their Medicare Administrative Contractor (MAC) for precise reimbursement rates and guidelines. Additionally, it's important to ensure that all

DSMES services meet Medicare's requirements for coverage, including being provided by a qualified health care professional and adhering to an approved curriculum.

Vermont Medicaid: Vermont Medicaid reimburses health care providers for delivering DSMES services, but the exact reimbursement rates depend on specific billing codes and provider qualifications.

While the Department of Vermont Health Access (DVHA) provides fee schedules detailing reimbursement rates, DSMES-specific codes and rates are not explicitly listed in the available documents. For instance, the April 2023 Fee Schedule and the Medicaid Quarterly Rate List for January 2025 offer comprehensive fee information, but they do not specifically address DSMES services.

In the absence of Vermont-specific DSMES reimbursement details, it can help to consider federal benchmarks. As of June 2022, the Centers for Medicare & Medicaid Services (CMS) set the national base rate for DSMES services at $187.19. This rate is subject to annual updates and geographical adjustments.

To obtain the most accurate and current information regarding DSMES reimbursement rates under Vermont Medicaid, providers are encouraged to:

- Contact the DVHA Clinical Operations Unit at 802-879-5903.
- Reach out to Vermont Medicaid Provider Services at 1-800-925-1706.
- Consult the DVHA's Codes and Fee Schedules page for the latest updates.

Private Insurance (e.g., BlueCross BlueShield of Vermont, MVP Health Care, Cigna): Generally, private insurers also reimburse DSMES services under the Health Care Common Procedure Coding System (HCPCS) codes G0108 and G0109.Coverage can vary widely among private insurers. Some may follow Medicare guidelines, while others may have their own policies regarding the number of reimbursable sessions. It's best to consult directly with the insurance provider. Information about accessing provider fee schedules for Vermont payers is below:

With BlueCross BlueShield, the codes for individual and group DSMES training are eligible for reimbursement. Certificates may stipulate that DSMES needs to be conducted by certain types of providers, but usually the provider types align with those specified as part of accreditation or recognition. Services are processed as office visits, and depending on the type of plan, they may have a co-pay or out of pocket deductible. Log in to the provider portal at https://www.bluecrossvt.org/provider-login for more information or contact your BCBS VT provider relations representative with questions.

The Vermont MVP provider fee schedule can be found in plan-specific documents like the MVP Plan Summary Spreadsheet. These documents outline costs for various services, including those for integrated medical, diabetes supplies, and more. Additionally, the UVM Health Advantage Summary of Benefits, which is offered through MVP, details in-network

and out-of-network costs for services like specialist and PCP visits. For specific rates, refer to the plan documents for your specific MVP plan, as costs can vary.

Accessing the full Cigna provider fee schedule for Vermont requires logging into the secure Cigna for Health Care Professionals website (CignaforHCP.com).

Detailed Steps:

- Log in: Go to CignaforHCP.com and log in with your provider credentials.
- Request Fee Schedule: Navigate to the "Working with Cigna" section and then click on "Request Fee Schedule".
- Provide Details: Enter the required information to specify the fee schedule you need, including details like provider ID, location, and zip code.
- Submit Request: Click submit to send your request.
- Retrieve Schedule: Your fee schedule will be available in your inbox on the website. You will receive an email notification when it's ready.

Strategy Theme #4: Participant Accessibility

Accessibility is crucial in DSMES because it ensures that all individuals, regardless of their physical abilities, socioeconomic status, language proficiency, or geographic location, can receive the support needed to manage their condition effectively. Without accessible education and support, people with diabetes may face barriers to understanding vital information about blood sugar monitoring, medication use, nutrition, and lifestyle adjustments, which can lead to poorer health outcomes. By making DSMES accessible, health care systems promote equity, empower individuals to take control of their health, and reduce the risk of complications associated with diabetes. Furthermore, accessibility fosters inclusivity and respect, reinforcing the idea that everyone deserves the tools and support necessary to live a healthy, fulfilling life.

Patient-centered diabetes care is an essential component of accessibility because it respects everyone's unique experiences, needs, and goals, empowering them to take an active role in managing their health. By focusing on what matters most to the patient—not just clinical targets like blood sugar-- health care providers can build trust, improve engagement, and support more sustainable self-management behaviors. Patient-centered care leads to better health outcomes, greater satisfaction, and a stronger sense of partnership between patients and their care teams.

This section introduces or reviews some important, patient-centered accessibility topics and offers a list of common accessibility concerns followed by more information on each with suggestions for improving accessibility and creating inclusive DSMES programming.

Accessibility *focuses on removing barriers proactively to ensure equal access for all individuals without the need for special modifications.*

Some important accessibility concepts to become familiar with include:

Accessibility refers to designing environments, services, and systems so that they are usable by everyone, regardless of ability, right from the start. It focuses on removing barriers proactively to ensure equal access for all individuals without the need for special modifications. For example, providing educational materials in multiple formats (like audio, braille, and plain language) makes them accessible to a wide range of people automatically.

Accommodation, on the other hand, involves making specific, individualized adjustments or modifications to address a person's particular needs when accessibility alone isn't enough. Accommodation is reactive and tailored, such as offering a one-on-one interpreter for a patient who is deaf or adjusting appointment times for someone who needs extra support.

In short: accessibility is about designing for everyone from the beginning; accommodation is about adapting for individual needs when necessary.

Bias is a general term that refers to a preference, prejudice, or unfair judgment for or against a person, group, or idea, often in a way that is closed-minded or unfair. Bias can be conscious (explicit) or unconscious, and it can influence behaviors, decisions, and attitudes in noticeable ways.

Implicit bias, specifically, refers to unconscious attitudes or stereotypes that affect our understanding, actions, and decisions without us even realizing it. These biases are automatic and often based on deeply ingrained social stereotypes. Unlike explicit bias, which is deliberate and intentional, implicit bias operates subtly, often conflicting with a person's stated beliefs and values.

In short: bias can be either conscious or unconscious, while implicit bias is always unconscious and automatic.

Ableism is discrimination, prejudice, or social prejudice against people with disabilities, based on the belief that typical abilities are superior. It shows up in attitudes, actions, systems, and structures that marginalize or disadvantage people who have physical, cognitive, emotional, or sensory disabilities. Ableism can be overt, like denying someone a job because of a disability, or subtle, like designing public spaces, technologies, or services without considering accessibility needs. It can also appear in language, assumptions, and stereotypes, for example, assuming someone's quality of life must be poor because they have a disability or a health condition like diabetes. Ultimately, ableism reinforces barriers that prevent disabled people from participating fully and equally in society.

Some ways that ableism can show up in health care include:

- **Dismissal of Symptoms**: Providers may assume that new health concerns are simply part of a patient's existing disability, leading to missed or delayed diagnoses.
- **Lowered Expectations**: Health care professionals may have biased beliefs that patients with disabilities cannot achieve good health outcomes, leading to less aggressive or comprehensive care.
- **Lack of Physical Accessibility**: Clinics and hospitals might not have accessible exam tables, medical equipment (like blood pressure cuffs or diagnostic tools), or facilities, making it difficult for patients with mobility impairments to receive proper care.
- **Communication Barriers**: Providers might not offer accessible communication options, such as interpreters for deaf patients or materials in plain language for patients with cognitive disabilities.
- **Exclusion from Health Promotion**: People with disabilities are often left out of general health promotion efforts (such as diabetes prevention programs or cancer screenings), reinforcing the idea that their health is less important.

- **Making Assumptions**: Providers may wrongly assume things about a patient's abilities, needs, sexuality, or desires—for example, assuming someone with a disability isn't sexually active and therefore doesn't need reproductive health care.

These examples show how ableism can lead to poorer health outcomes, loss of trust in the health care system, and overall inequities in health care access and quality.

Ageism is discrimination or prejudice against individuals based on their age. It often involves stereotypes or negative assumptions, particularly about older adults, such as believing they are less capable, resistant to change, or a burden on society. Ageism can affect people in many areas of life, including employment, health care, and social interactions, and it can lead to unfair treatment, isolation, and reduced opportunities. Similarly, ageism toward young people can show up in ways that dismiss their abilities, ideas, or experiences simply because of their age. For example, young people might be seen as lazy, entitled, or inexperienced, even when they're qualified and capable. Their opinions may be overlooked in discussions or decision-making, and they might be denied leadership roles or serious responsibilities.

Some ways ageism can show up in health care include:

- Assumptions about aging: Providers may assume that symptoms like fatigue, memory loss, or pain are just a "normal" part of aging, rather than signs of a treatable condition.

- Under-treatment or over-treatment: Older adults may be under-treated because of beliefs that they won't benefit from certain procedures, or over-treated without considering their quality of life or personal wishes.

- Lack of respect for autonomy: Health care providers may speak to family members instead of directly to the older patient, assuming they can't make decisions for themselves.

- Dismissal of concerns: Younger patients may be told they're "too young" to have certain conditions or that their symptoms are just stress or overreaction.

- Limited access to mental health care: Both older and younger people may face barriers to getting mental health support due to stereotypes, like believing older adults can't benefit from therapy or that young people are just going through a phase.

These forms of ageism can lead to misdiagnosis, delayed treatment, and reduced trust in the health care system.

Some important considerations to ensure that DSMES services are accessible to all include:

- Physical Accessibility
- Inclusivity and Unbiased Care
- Communication Accessibility
- Cultural Relevance
- Affordability
- Technological Access
- Geographic Reach
- Health Literacy
- Policy and Legal Compliance
- Patient-Centered Design

Here are some suggestions for promoting DSMES accessibility in each of the areas listed above.

Physical Accessibility: Facilities must be easy to navigate for people with mobility challenges, including wheelchair access, ramps, elevators, and appropriate signage. Suggestions for improving physical accessibility in DSMES care include:

- Accessible Locations: Choose venues that are wheelchair accessible, have accessible parking spaces, curb cuts, ramps, elevators, and automatic doors.
- Adjustable Equipment: Use adjustable-height chairs, tables, and exam equipment, including wheelchair-accessible weight scales and blood pressure cuffs of varying sizes.
- Clear Pathways: Ensure waiting areas, bathrooms, classrooms and meeting areas have wide, unobstructed pathways for people using mobility aids (wheelchairs, walkers, scooters).
- Seating Accommodations: Offer a variety of seating options to meet different physical needs, such as a mix of chairs with and without armrests, chairs without wheels, or cushioned seats.
- Accessible Restrooms: Confirm that restrooms meet ADA (Americans with Disabilities Act) standards, including grab bars, appropriate toilet height, and accessible sinks.
- Assistive Technology: Provide access to assistive listening devices, microphones, or real-time captioning services for participants who are hard of hearing.
- Flexible Formats: Allow participants to attend sessions virtually if physical barriers prevent in-person attendance, ensuring online platforms are accessible too.
- Transportation Support: Help coordinate accessible transportation options or provide information about paratransit services if needed.
- Signage and Wayfinding: Use clear, large-font, high-contrast signage and braille throughout the facility to assist those with visual impairments.
- Inclusive Emergency Plans: Ensure that emergency exits and evacuation procedures are inclusive and accessible for people with disabilities.

People with diabetes experience **stigma** because of body size and perceived lifestyle factors. Creating a respectful, weight-inclusive care environment is essential for promoting better engagement, health outcomes, and overall well-being in people with diabetes. Lifestyle is very often influenced by social drivers of health over which the patient may have little or no control. You can learn more about weight inclusive nutrition education and the science behind it at the University of Vermont's Weight Inclusive Nutrition Research Group webpage.

45. Use Respectful, Person-Centered Language
    Focus on the person, not their body size. For example, say "person *with* diabetes" rather than labeling someone as a "diabetic" or "obese" patient in documentation and in general conversation. One caveat to this suggestion is that some people refer to themselves as diabetic as an acknowledgement that managing diabetes is an important part of their identity. When talking with a patient, it is important to ask them what they prefer and follow their lead.

46. Avoid Making Assumptions About Health Based on Weight
    Recognize that weight alone is not necessarily an indicator of a person's health, behaviors, or diabetes management success. Avoid assuming that weight loss should be a primary goal and the primary measure of success.

47. Focus on Health Behaviors, Not Weight
    Emphasize achievable, sustainable behaviors like nutritious eating, regular, enjoyable movement, good sleep habits, stress management, and medication therapy, rather than focusing on weight loss as an outcome. Weight is not a behavior nor an action that can be taken. Talk with the patient about what feels achievable to them. What would help them meet their goals? Motivational interviewing tools and processes can help facilitate patient-centered conversations.

48. Create a Welcoming, Non-Judgmental Environment
    Ensure that seating in the waiting area and exam rooms is accessible for all body sizes, use simple décor that does not depict people, animals, food, etc. and ensure medical equipment (scales, blood pressure cuffs) accommodates people of all body sizes comfortably and respectfully.

    Weight alone is not necessarily an indicator of a person's health, behaviors, or diabetes management success.

49. Train Staff on Weight Bias
    Provide regular education and reflection opportunities for health care teams about recognizing and addressing their own implicit biases related to body size.

50. Offer Weight-Neutral Care Options

Use models like Health at Every Size® (HAES®) or weight-inclusive approaches that prioritize overall well-being rather than treating weight as a problem to be fixed.

51. Ask for Consent Before Weighing
    Explain why weighing may be medically necessary in certain situations and give patients the option to decline being weighed (or omit weighing altogether) if it's not essential to their care.

52. Include Diverse Body Types in Educational Materials
    Ensure that pamphlets, videos, and other diabetes education resources feature people of varied sizes, abilities, and backgrounds, promoting representation and belonging.

53. Listen and Validate Patients' Experiences
    If a patient shares experiences of weight stigma, listen without judgment and acknowledge the harm they may have experienced in health care settings.

54. Advocate for Systemic Change
    Support policies and practices that promote weight-inclusive and anti-discrimination efforts within health care organizations and diabetes care programs.

A simplified checklist of DSMES accessibility and inclusion considerations can be found on the VDH DSMES Support Page and as appendix X in this document.

Information should be available in multiple formats (e.g., large print, braille, audio, easy-to-read language) and interpreters (such as ASL interpreters) should be provided when needed.

55. Use Plain Language and Visual Aids
    Avoid medical jargon and explain concepts in everyday terms. Reinforce messages with visuals like diagrams, videos, or models. Use the teach-back method to confirm understanding.

56. Offer Information in Multiple Formats
    Provide materials in accessible formats such as large print, braille, audio, easy-read versions, and multiple languages to meet diverse communication needs.

57. Ensure Language and Interpretation Access
    Offer professional spoken language or sign language interpreters and deliver education in a person's preferred language using bilingual staff or translated materials. Allow longer appointments for people with language access needs.

58. Make Digital Tools Accessible
    Design telehealth platforms and online portals to be screen reader–friendly, caption videos, and use clear, high-contrast layouts.

59. Adapt to Individual Preferences and Needs
    Ask patients how they prefer to receive information—verbally, in writing, or digitally—and allow extra time or quiet environments when needed for better focus and understanding.

60. Respect Cultural Beliefs and Practices
    Tailor education to reflect patients' cultural values, including traditional foods, health beliefs, and family roles. Be open to integrating traditional practices where appropriate. Instead of replacing cultural foods, help patients find ways to enjoy them in a diabetes-friendly way.

61. Hire and Train a Diverse, Inclusive Team
    Employ staff who reflect the communities served, and train all team members on inclusive communication, cultural humility, and respectful care.

62. Be Mindful of Sensory Needs
    Allow for quiet, low-light, distraction-free environments for people who have sensory challenges, cognitive disabilities, or attention challenges.

63. Be Open, Humble, and Curious
    Practice cultural and situational humility—be willing to listen, ask questions, and adapt your approach based on what matters most to the person and their community. Include members of the community in program planning when possible.

High costs can be a major barrier to diabetes care and education. Most insurance will cover DSMES services, but patients may be responsible for copays as well as the cost of medications, equipment, and lifestyle supports such as nutritious foods, accessories to support exercise, etc. Understanding a patient's financial barriers and helping them access insurance or financial assistance is critical.

64. Offer Sliding Fee Scales or Free Programs
    Provide education programs with sliding scale pricing based on income or offer free community-based classes supported by grants or public health funding.

65. Leverage Insurance Coverage
    Help patients understand and use their insurance benefits, including Medicare or Medicaid, which often cover diabetes self-management education and support (DSMES) if referred by a provider.

66. Partner With Community Organizations
    Collaborate with local nonprofits, health departments, and faith-based groups that can help subsidize or host free programs in trusted community spaces. Across Vermont, there are several community organizations that may be available to collaborate, such as Support and Services at Home (SASH), supermarkets that incorporate dietitians, Area Agencies on Aging, and offices of local health.

67. Use Group Education Sessions
    Offer group classes such as My Healthy Vermont workshops.

68. Provide Transportation Support
    Offer or coordinate low-cost or free transportation options to reduce the burden of getting to appointments, especially in rural or underserved areas. Vermont Medicaid provides non-emergency transportation to appointments for covered services to members who don't have access to their own transportation.

69. Include Community Health Workers
    Train community health workers or peer mentors to deliver education, which can reduce staffing costs and improve cultural connection and trust.

70. Apply for Grants and Funding
    Seek funding from the Vermont Department of Health, foundations, or corporate sponsors to offset the cost of materials, staffing, or technology for diabetes education programs.

71. Create Low-Cost Educational Materials
    Develop simple, cost-effective handouts or toolkits that patients can take home, using plain language and visuals to reduce the need for repeated in-person instruction. Direct patients to reputable, free or low-cost online diabetes education resources, apps, and webinars that they can access on their own time.

72. Advocate for Policy Support
    Support local and national policy efforts to increase funding for diabetes education, expand insurance coverage, and remove copay barriers for DSMES services.

Technological Access: Telehealth platforms should be easy to use and compatible with assistive technologies. Internet access and digital literacy support may also be necessary.

73. Offer Telehealth Appointments
    Provide virtual DSMES sessions via secure video platforms so people in rural, remote, or underserved areas can participate without travel. For simple follow up appointments, can you utilize the telephone or portal/email messaging?

74. Use Mobile Apps for Self-Management
    Recommend evidence-based apps that help patients track blood glucose, meals, medications, and activity. Choose apps with easy interfaces, multiple languages, and accessibility features (like voice controls or screen reader compatibility).

75. Provide Online Education Modules
    Create or share interactive, on-demand lessons that people can access anytime, allowing flexibility for different schedules and learning styles.

76. Enable Text Messaging Support
    Use SMS reminders or tips to reinforce key DSMES messages, such as medication adherence, appointment reminders, or motivational support—ideal for patients without smartphones or internet.

77. Use Captioned Videos and Visual Learning Tools
    Incorporate video content with captions, sign language interpretation, and visual aids to support people with hearing impairments or low literacy.

78. Ensure Digital Platforms Are Accessible
    Choose platforms that meet Web Content Accessibility Guidelines (WCAG)-compatible with screen readers, high-contrast settings, and keyboard navigation.

79. Offer Digital Health Coaching
    Connect patients with virtual diabetes coaches or peer mentors for support via video, phone, or chat, especially helpful for those with mobility or transportation barriers.

80. Create Culturally and Linguistically Tailored Content
    Use technology to provide DSMES content in multiple languages, incorporating cultural references and examples that resonate with diverse populations.

81. Provide Tech Support and Training
    Offer simple training or tech support for patients unfamiliar with digital tools. This can include short tutorials or live help setting up apps or video visits.

82. Integrate With Wearables and Glucose Monitoring Devices

Help patients link continuous glucose monitors (CGMs), insulin pumps, or fitness trackers with their DSMES plan for real-time, personalized feedback and better data sharing with educators.

Geographic Reach: Services should be available to people in rural and underserved areas, through satellite clinics, telemedicine, and partnerships with local organizations. Strategy Theme #5 focuses on partnering with community-based organizations to offer DSMES in accessible spaces.

Health Literacy: Educational materials and interactions should be understandable to individuals with varying levels of health knowledge, avoiding jargon and emphasizing clear instructions. It is important to address health literacy respectfully by using visuals, stories, and interactive teaching methods to support understanding without making assumptions about a person's education level.

Policy and Legal Compliance: Diabetes care providers must comply with laws like the Americans with Disabilities Act (ADA) and other regulations protecting patients' rights to accessible care.

Patient-Centered Design: Involving patients with disabilities and other underserved groups in planning and evaluating services ensures that accessibility efforts are truly meeting community needs.

Strategy Theme #5: Community-Based Settings

Community-based organizations (CBOs) can play a pivotal role in expanding access to Diabetes Self-Management Education and Support (DSMES) by forming strategic partnerships with clinical organizations. These collaborations leverage the strengths of both entities. Below is a breakdown of the potential roles and strengths that CBOs and clinical organizations can each contribute to a successful DSMES partnership.

CBOs can be ideal settings for DSMES because they are trusted, accessible, and deeply connected to the populations they serve. CBOs bring trust, accessibility, cultural relevance, and community connection — all of which are essential for the success of DSMES. More specifically, some key factors that make the CBO setting ideal include:

- Deep Community Trust and Relationships
  CBOs are often embedded within the communities they serve. They have long-standing relationships and cultural credibility, which builds trust — a crucial factor when discussing sensitive topics like health behaviors and chronic disease management.

- Cultural and Linguistic Relevance
  CBOs are often staffed by people who:
  - Share the cultural background of participants
  - Speak the community's primary language
  - Understand community norms, challenges, and values

  This allows DSMES programs to be tailored to the unique needs and beliefs of the people they serve, increasing engagement and effectiveness.

- Accessibility
  CBOs are in areas where high-risk populations live, making them:
  - Easier to access (physically and financially)
  - Less intimidating than clinical settings
  - More likely to serve people who might not seek help elsewhere

  This reduces barriers like transportation, cost, and fear of medical institutions.

- Peer Support and Social Connectedness
  Many CBOs already provide group-based programs, peer mentoring, and support networks. These social connections are powerful motivators in chronic disease management, helping people stick with behavior changes.

- Integration with Other Services
  CBOs often offer wraparound services, such as:
  - Food and nutrition programs

- Housing support
- Employment assistance
- Mental health services

DSMES can be integrated into these offerings, making care more holistic and responsive to social drivers of health.

- Flexibility and Innovation
  CBOs often have more flexibility than health systems in how they deliver services. They can:
  - Hold classes at convenient times
  - Include community health workers (CHWs)
  - Offer education in churches, libraries, or homes

  This helps DSMES programs reach people where they are — literally and figuratively. In partnerships between community-based organizations (CBOs) and clinical organizations to offer DSMES, clinical organizations also play a pivotal role in ensuring the medical integrity and effectiveness of the program. Their contributions may include:

- Clinical Oversight and Expertise: Clinical organizations provide the medical knowledge and oversight necessary for DSMES programs. They ensure that the education and support offered align with current clinical guidelines and standards of care. This includes contributing to curriculum development and ensuring that the information provided is accurate and evidence-based.
- Referral Systems: They establish and maintain referral pathways, connecting patients to DSMES services. By identifying eligible patients and referring them to appropriate programs, clinical organizations facilitate patient access to essential self-management education.
- Data Sharing and Coordination: Clinical organizations are responsible for sharing relevant patient data with CBOs, ensuring coordinated care. This includes developing data-sharing agreements that comply with privacy regulations and support the monitoring of patient progress.
- Training and Support: They may provide training and support to CBO staff, enhancing their capacity to deliver DSMES effectively. This collaborative approach ensures that community educators are well-equipped to address the diverse needs of patients.
- Evaluation and Quality Improvement: Clinical organizations participate in the evaluation of DSMES programs, contributing to quality improvement initiatives. By analyzing outcomes and providing feedback, they help refine program delivery and effectiveness.

Through these roles, clinical organizations ensure that DSMES programs delivered in community settings are medically sound, effectively coordinated, and responsive to patient needs, thereby enhancing the overall quality and reach of diabetes care.

Partnering community-based organizations or settings for DSMES may include:

- Libraries
- Senior centers
- Shopping malls
- Food pantries
- Housing sites
- Faith-based organizations
- Pharmacies
- Home health programs
- Community action organizations
- Continuing education sites
- Area Agencies on Aging
- Offices of Local Health
- Town halls or Granges
- Fraternal orgs, veteran/military orgs (Lions Club, Elks Club, Veterans Association, etc.)

Examples of successful CBO-based DSMES programs

JOSLIN LATINX DIABETES INITIATIVE (LDI)

Location: Boston, MA — in partnership with local community centers and churches.
Key Features:

- Culturally tailored DSMES offered in Spanish
- Delivered in community settings (not hospitals), including churches and senior centers
- Staffed by bilingual, bicultural educators and community health workers
- Curriculum integrates:
    - Nutrition advice based on traditional Latino foods
    - Family involvement (key in Latino culture)
    - Group sessions and peer support

Outcomes:

- Participants showed improved A1C levels, better medication adherence, and lifestyle changes
- Higher engagement and lower drop-out rates than traditional clinic-based programs
- Increased diabetes knowledge and confidence in self-management

More Information:

Joslin Latinx Diabetes Initiative (LDI)

REACH DETROIT PARTNERSHIP

Location: Detroit Michigan
Key Features: The Reach Detroit Partnership works with local CBOs and faith-based groups to deliver DSMES in African American and Latino communities using trained community health workers
Outcomes:

- Reductions in A1c
- Improved self-care behaviors
- Improved access to health care

More Information:

- REACH Detroit Partnership

These models show that when DSMES is rooted in the community, it's not only more accessible and trusted, but also more likely to succeed in improving outcomes, particularly in historically underserved populations. It is important to note that a fundamental component of CBO-based DSMES is a strong partnership with a clinical care organization.

Strategy Theme #6: Vermont Department of Health Support

Operating a successful DSMES program, especially in the early stages, can be complex. There are many online resources to support DSMES accreditation and recognition; understandably, it can be difficult to find the help you need. The positive outcomes for patients are well-documented and the Vermont Department of Health (VDH), with support for the Centers for Disease Control (CDC) is committed to tailoring support to ensure that DSMES can become more widely available in Vermont. VDH can support a new or sustaining DSMES program in several ways. As with the rest of this document, please use what is helpful to you and leave the rest. Below are descriptions of resources that can be found at www.XXXX.gov.

- Programmatic Support
    - Incorporation of the My Healthy VT (MHVT) DSMP to cover the education portion of DSMES for people with type 2 diabetes; there is no cost to your organization.
        - Process is in development and will be made available on the VDH DSMES webpage when ready.

- Financial Support
    - Initial fee (not sustaining)
      VDH has an annual budget to support the initial fee for new accreditation or registration applications. Funds will be distributed on a first come first served basis. Please reach out to the VDH Diabetes Program to inquire about availability. AHS.VDHHPDPDSMES@Vermont.gov

- Administrative Support
    - Technical Assistance
        - The VDH Diabetes Team, which includes a DSMES Quality Specialist, is available to help with questions or challenges related to new or sustaining DSMES accreditation. For assistance, please reach out to: AHS.VDHHPDPDSMES@Vermont.gov
    - Training Hub
        - Access to recorded trainings for DSMES care team members who are not a CDCES or BC-ADM to support the required 15 hours of diabetes-related continuing education.
    - Updated DSMES Site Locator
        - New accredited and recognized organizations will be added to the site locator every six months.

        - *Or* organizations may contact VDH at any point with notification that they have a newly accredited or recognized program that they would like added to the site locator.
    - ADCES Simplified Steps to Accreditation- CHECKLIST
    - ADCES Simplified Steps to Accreditation- FLOWCHART
    - Up to Date Resources: The following are available on the DSMES support page
        - Sample letter of support (Standard 1)
        - Description of populations of focus and diabetes-related demographics by county (Standard 2)
        - Template to track care team training hours (Standard 3)
        - A description of the process for using the My Healthy VT diabetes self-management program (DSMP) for the self-management education/curriculum portion of DSMES (Standard 4)
        - Template for an ADCES-compliant documentation of interaction (SOAP format) (Standard 5)
        - ADCES Outcome Examples Table (Standard 6)
    - Frequently Asked Questions (FAQ)
        - Please visit the VDH DSMES support page to view curated responses to FAQ. FAQs have been developed and answered with the support of existing accredited or recognized DSMES programs and ADCES.
    - Umbrella Status
        - VDH aims to explore the possibility of eventually becoming an umbrella organization to maximize the support available to organizations seeking accreditation or recognition. Umbrella status will be dependent on staff capacity, status of the Diabetes Program's cooperative agreement with the CDC, and ability to meet ADCES and/or ADA requirements for umbrella organizations.