Insight into Diabetes Care in Vermont: Results of the 1815 Cooperative Agreement

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VERMONT
DEPARTMENT OF HEALTH

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Executive Summary

Vermont's Work to Improve Diabetes Prevention and Management

Diabetes remains a significant public health concern in Vermont. More than **49,000 Vermonters** live with a diabetes diagnosis, and an estimated **one in four remain undiagnosed**. The condition is a major contributor to morbidity and mortality, increasing risk for cardiovascular disease, chronic kidney disease, and other comorbidities. Preventing or delaying the onset of type 2 diabetes and improving management of existing cases are essential for reducing long-term health and economic burdens.

In 2018, the Vermont Department of Health (VDH) was awarded the **"Improving the Health of Americans through Prevention and Management of Diabetes and Heart Disease and Stroke"** (CDC-RFA-DP-1815) cooperative agreement from the U.S. Centers for Disease Control and Prevention (CDC). This five-year initiative (2018–2023) focused on implementing and evaluating evidence-based interventions that strengthen clinical and community systems to prevent and manage Type 2 diabetes statewide.

The 1815 Cooperative Agreement focused on three overarching goals:

- **Expand access to and retention in diabetes self-management programs.**
- **Increase adoption and use of clinical systems and care practices that improve outcomes.**
- **Reach and support populations disproportionately affected by diabetes**, including individuals with disabilities, those with low socioeconomic status, rural residents, new Americans, older adults, and Abenaki citizens.[1]

To achieve these goals, the Vermont Department of Health (VDH) partnered with eight Federally Qualified Health Centers (FQHCs), two hospital-owned health systems, a community pharmacy, and a statewide housing organization serving older adults. Collectively, these partners are referred to throughout this document as the **"1815-funded organizations."** VDH also collaborated with the Bi-State Primary Care Association, which provided technical assistance, data reporting support, and quality improvement training to participating FQHCs.

Together, these 1815-funded organizations **served more than 90,000 adults aged 18–85** through direct services and systems-level interventions[2], despite the challenges faced by the COVID-19 pandemic. To share lessons learned, the Vermont Department of Health

[1] **Note**: Populations identified based on data available in 2018.
[2] 2023 Vermont Health Systems Quality Improvement Assessment.

developed this resource to support health professionals and organizations working with individuals who have, or are at risk for, diabetes.

This report presents insights, implementation strategies grounded in best practices, challenges encountered, and practical resources drawn from Vermont's 1815-funded work. Applying these lessons can help organizations strengthen diabetes prevention and management systems, enhance coordination between clinical and community partners, and improve population health outcomes across Vermont.

Insights include:

- Strengthening Clinical and Organizational Systems
  1815-funded organizations demonstrated that adopting team-based care models, standardized clinical protocols, and optimized electronic health records (EHRs) improves coordination, consistency, and quality of care across settings.
- Expanding Self-Management and Prevention Efforts
  Collaboration with *My Healthy Vermont (MHVT)* expanded statewide access to Diabetes Prevention and Self-Management Programs. Flexible delivery options, including virtual and hybrid formats, helped sustain participation and reach rural and older populations.
- Reducing Barriers and Advancing Health Equity
  1815-funded organizations applied a health equity lens to identify and reduce barriers to care, including limited technology access, transportation challenges, and food insecurity. Integrating community health workers and screening for social determinants of health strengthened linkages to community supports.
- Building Data Capacity and Continuous Improvement
  Enhanced EHR functionality and population health tools supported systematic tracking of quality measures, identification of gaps in care, and targeted outreach. Continuous data review and quality improvement practices enabled organizations to sustain progress and adapt to evolving needs.

The 1815 initiative strengthened Vermont's infrastructure for diabetes care through integrated clinical systems, evidence-based protocols, and community partnerships. It positioned the state for continued progress by embedding prevention and management practices within routine care and aligning future efforts with Healthy Vermonters 2030 goals. Ongoing collaboration will focus on sustaining CHW integration, maintaining access to self-management programs, and leveraging data to drive equity and improved outcomes statewide.

Authors & Featured Organizations

Authors: Vermont Department of Health

Featured Organizations

This document highlights the work and experiences of:

- Community Health Centers of Burlington (CHCB)
- Northeastern Vermont Regional Hospital (NVRH)
- Northern Counties Health Care Inc. (NCHC)
- Little Rivers Health Center (LRHC)
- Battenkill Valley Health Center
- Northern Tier Center for Health (NOTCH)
- Gifford Health Care
- Appletree Bay Primary Care (ATB)
- Support and Services at Home (SASH)
- Brandon Pharmacy

Additional funding supported the Bi-State Primary Care Association to provide technical assistance to participating FQHCs, including community of practice calls, diabetes and health equity-related trainings and one-on-one support for data extraction and reporting.

Source Content

The remaining content draws from federal guidance, peer-reviewed publications, and other publicly available public health resources.

Contributors & Reviewers

The following individuals and organizations provided subject matter expertise, identified tools and resources, and conducted document review: Northern Counties Health Care, Inc., and the Vermont Department of Health Diabetes Program.

IMPROVING SYSTEMS & ORGANIZATIONAL INFRASTRUCTURE

As the health care system becomes increasingly complex, strengthening organizational infrastructure is crucial for enhancing patient satisfaction, improving health outcomes and promoting provider well-being while reducing costs. Effective systems are the foundation for coordinating patient-centered care, particularly for individuals with diabetes or at risk. Key strategies include building strong care teams, optimizing electronic health records and developing standardized protocols. Through 1815 funding, organizations implemented a range of activities to advance these critical systemic improvements.

I. Team-Based Care

Team-based care is a model of health care delivery where patient needs are met through coordinated efforts among health care providers and community partners. In diabetes care, team members bring expertise in prevention, management, and support. Evidence shows this approach improves blood glucose (A1C, blood pressure, and lipid levels[3].

Challenges to Consider

- **Limited staff time, limited resources, and high turnover**
- **Uncertainty about team roles and optimal structure**
- **Social/professional hierarchies and provider resistance to change**
- **Limited leadership support and financial investment**
- **Patient reluctance or lack of trust in expanded care teams**

Implementation Strategies

Engage Leadership
Secure leadership support and ensure clear communication to advocate for the prioritization of care for diabetes in resource allocation and funding decisions. This involves sharing relevant data, compelling stories, and evidence that highlights the critical need for attention and investment in diabetes care.

Form a Team: Include diverse professionals such as Certified Diabetes Care and Education Specialist (CDCES), dietitians, nurses, providers, pharmacists, Community Health Workers (CHWs), and social workers. 💡 **Tip:** Don't forget front desk staff, they're the first point of patient connection. And include IT staff, who can support EHR access and smooth data management.

10% **of Vermont pharmacists work at a pharmacy that offers hemoglobin A1c testing.**

Source: Chronic Disease Care in Vermont Pharmacy Settings, 2022 Vermont Behavioral Risk Factor Surveillance System, 2021

[3] *Diabetes management: Team-based care for patients with type 2 diabetes* (2023) *The Community Guide*. Available at: https://www.thecommunityguide.org/findings/diabetes-management-team-based-care-patients-type-2-diabetes.html (Accessed: 10 Jan 2025).

Designate a Champion: Appoint a leader (e.g., physician or Quality Improvement lead) to guide diabetes care transformation. Champions act as mentors, engage providers and optimize resources.

Clarify Roles & Expectations: Define team roles and scope of practice. 💡 **Tip:** Provide all members with EHR/EMR access. Evidence shows shared record access reduces A1C[4].

Provide Training: Offer training to strengthen collaboration (e.g., Motivational Interviewing, Team-Based Care 101). Include training on equity, diversity, and implicit bias.

60% of 1815 funded organizations achieved full EHR access

Ensure Ongoing Communication: Maintain structured feedback loops (huddles, meetings, emails, EHR messaging). This can build sustainability and team accountability.

Partner with Patients: Involve patients, families, and caregivers as active team members. Clarify each team member's role with the patient to support informed decision-making.

"This model allows for patients to have increased access to patient education, behavioral health services, self-management support and care coordination."- Northeastern Vermont Regional Hospital

Vermont Team Based Care Examples

Community Health Workers:

Northeastern Vermont Regional Hospital operates the *Community Connections (CoCo)* program, a well-studied initiative that bridges gaps between health care and social services. CHWs support patients in self-managing conditions like diabetes while addressing broader clinical needs. Supported by the 1815 cooperative agreement, CoCo piloted a diabetes project to raise awareness of the CHW role and increase provider referrals for diabetes health coaching.

[4] Diabetes Management: Team-Based Care for Patients with Type 2 Diabetes. Corporate Authors(s): Community Preventive Services Task Force (CPSTF). Published Date: 2016/12/01. DOI: https://doi.org/10.15620/cdc/164196

Pharmacist Integration

- Northeastern Vermont Regional Hospital integrated pharmacists into medication therapy management via collaborative practice agreements to enhance diabetes care.
- Brandon Pharmacy, embedded within a Federally Qualified Health Center (FQHC), coordinated with the medical team and the MyHealthy VT program to refer eligible patients for diabetes self-management support.

Partnerships with Specialists

- Northern Counties Health Care Inc. launched the *Passport Program* with Dartmouth Endocrinology, reducing barriers to specialist care such as transportation and scheduling.
- Community Health Centers of Burlington implemented a hybrid virtual model connecting patients, endocrinologists, pharmacists, and dietitians remotely.

Diabetes Provider Champions

Gifford Health Care established a dedicated diabetes team with a provider champion who mentored colleagues, supported EHR utilization and promoted adherence to the health center's protocol.

II. Diabetes Prevention & Management Protocols

A diabetes protocol—also called a workflow, pathway or clinical care guideline—guides teams in providing consistent, evidence-based care for patients with or at risk for diabetes. Protocols cover screening, diagnosis, monitoring, treatment goals and interventions throughout disease progression, supporting coordinated care and improved patient outcomes.

Implementation Strategies

Define the Purpose and Scope

- Identify the goals of the protocol (e.g., improving glycemic control, standardizing care, supporting prevention).
- Specify the patient population (type 1, type 2, prediabetes, pediatric, gestational, adult) and determine the settings where it will be applied (primary care, specialty clinics, telehealth).

Review Current Guidelines and Evidence

- Consult national and state guidelines (e.g., American Diabetes Association (ADA), Vermont Department of Health) and review literature on best practices for diabetes screening, monitoring, and treatment. *The ADA's Standards of Care in Diabetes were revised in 2025.*
- Examine existing protocols within your organization or peer institutions.

Map the Clinical Workflow

- Outline steps for screening, diagnosis, monitoring, treatment, and follow-up. Identify responsibilities for each team member. 💡 **Tip:** Include clear pathways to diabetes self-management programs and Diabetes Prevention Programs (e.g., MyHealthy VT).
- Consider bi-directional referral systems linking medical care, dental care and social services (e.g. FindHelp).

Incorporate Tools and Resources

- Integrate EHR templates, order sets, alerts, and population health tools.
- Include pre-visit planning checklists and risk assessment tools.

Define Metrics and Evaluation

- Decide what to measure: e.g., A1C levels, medication adherence, problem list utilization, etc., and establish benchmarks and reporting frequency.

Draft the Protocol

- Use clear, concise language with flowcharts or stepwise guidance. Include references to guidelines, clinical decision points and patient education materials.

"Having a cohesive approach to prediabetes and diabetes in a practice has been key to helping patients in achieving their A1C and blood pressure goals. When a provider sees a patient and begins pharmacologic therapy, the next provider that sees the patient knows exactly what needs to be done next and follows through with the patient whereas, in many practices when multiple providers are seen by a patient, the ball gets dropped."
- Appletree Bay Primary Care

Pilot and Refine

- Test with one provider, team, or clinic site. Collect feedback on workflow, usability and patient outcomes. Adjust before organization-wide rollout.

Train Staff and Educate

- Conduct team training sessions, share handouts and provide access to protocol documents. Ensure staff understand their roles and the rationale behind each step.

Implement and Sustain

- Launch the protocol across the organization. Schedule regular reviews to update with new evidence, medications, and guideline changes.

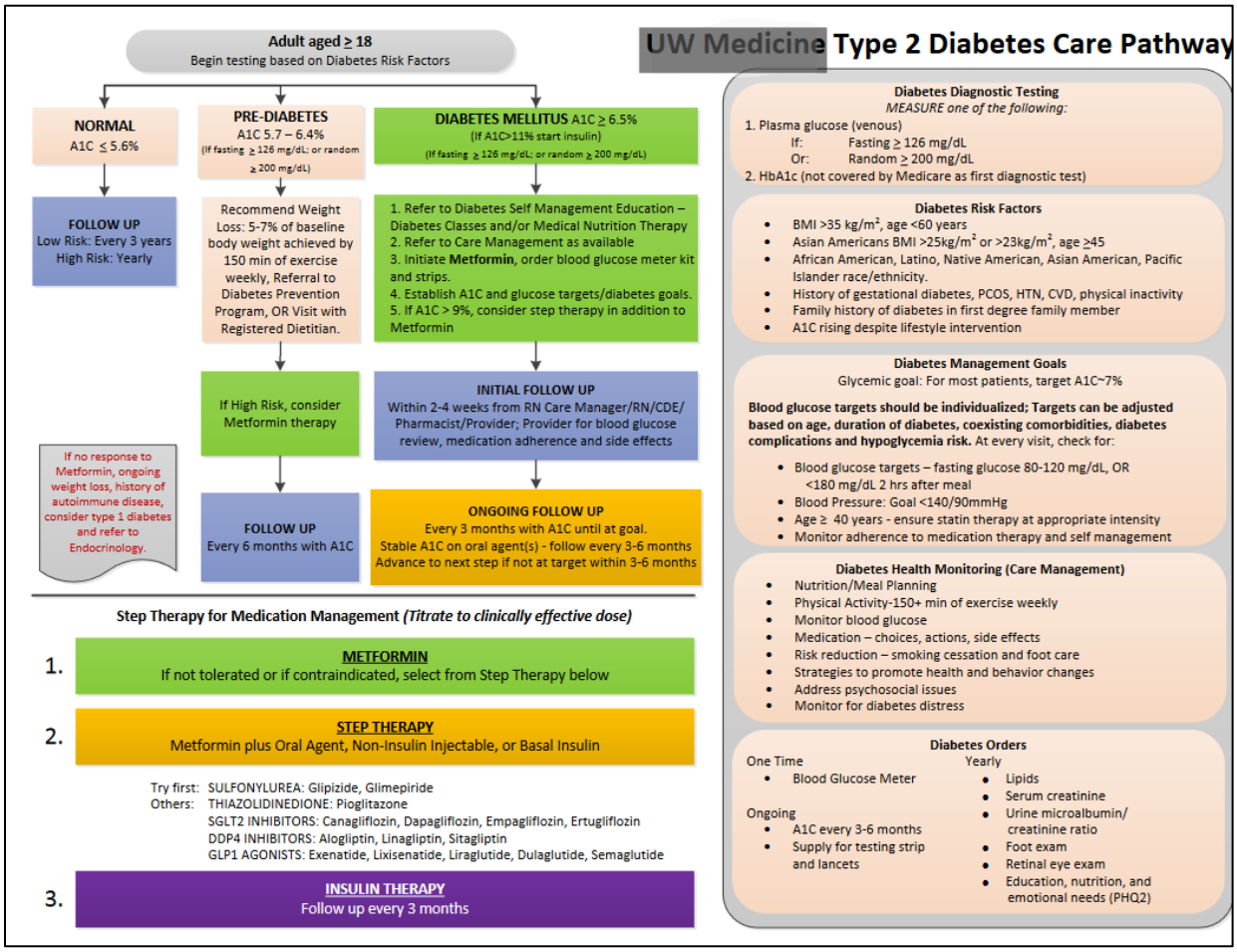
  💡 **Tip:** Use quality improvement initiatives to monitor effectiveness and adherence.

By 2023, all 1815 funded organizations had a formalized protocol for diabetes prevention and management

Source: Vermont Health Systems Quality Improvement Assessment (VHSQIA), 2023

Diabetes Protocol Example

This protocol image illustrates a sample diabetes workflow for practices; however, each organization can develop and tailor its own to fit specific needs and resources.



Source: UW Medicine Type 2 Diabetes Care Pathway. Source: University of Washington Medicine (n.d.).

III. Electronic Health Records or Population Health Platform

An Electronic Health Record (EHR) or Population Health Platform is a digital patient chart that provides secure, real-time access to care records. EHRs link data across labs, pharmacies, inpatient, and outpatient sites, supporting both individual care (e.g., overdue eye exams) and population-level tracking (e.g., proportion of patients with neuropathy). They enable lab and medication orders, provide prompts and secure patient messaging. Evidence shows that using EHRs improves the quality of diabetes care compared with paper records.[5]

Challenges to Consider

Limited leadership support and resources

Inconsistent provider adherence

Sustainability issues (staff turnover, shifting priorities, EHR/vendor changes)

Protocols lag behind frequent care guideline updates

EHR limitations and high upgrade/IT costs

Implementation Strategies

Assess EHR capabilities: Identify system functions, align organizational priorities, secure leadership support, and evaluate features that best support diabetes care.

Provide staff education: Educate staff on how to utilize the EHR to support diabetes care.

> *"Staff education is a key first step in implementing a successful process for identifying and supporting patients with diabetes."*
> *-The Northern Tier Center for Health (NOTCH).*

Population Health:

- Generate lists of patients with diabetes eligible for self-management or prevention programs (e.g. MyHealthy VT).
- Identify populations disproportionately affected by diabetes (income, education, race, LGBTQ+, disability).

[5] Vaghefi I, Hughes JB, Law S, Lortie M, Leaver C, Lapointe L. Understanding the Impact of Electronic Medical Record Use on Practice-Based Population Health Management: A Mixed-Method Study. JMIR Med Inform. 2016;4:e10. doi: 10.2196/medinform.4577.

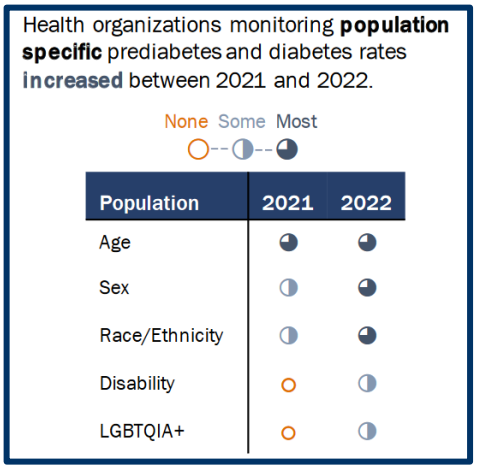
- Create dashboards to monitor quality measures, including updated A1C testing and referrals to programs like My Healthy VT (MHVT), CDCES, dietitians and social services.

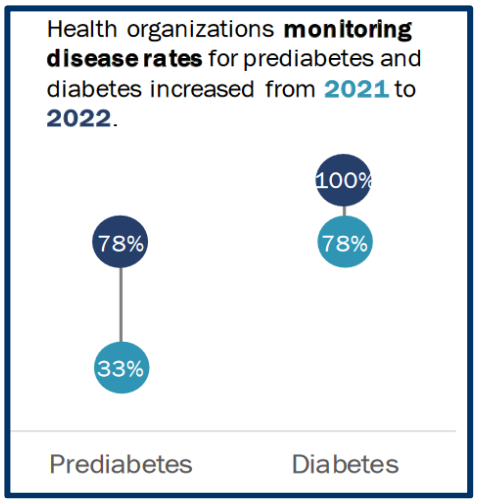
Clinical Decision Support:

- Embed diabetes protocols/workflows into the EHR.
- Implement preventive care prompts and expand access for care team members.
- Increase telehealth capabilities for flexible, real-time monitoring and better understanding of patients' living situations.

Patient Engagement:

Use portals to educate patients on self-management and program referrals.



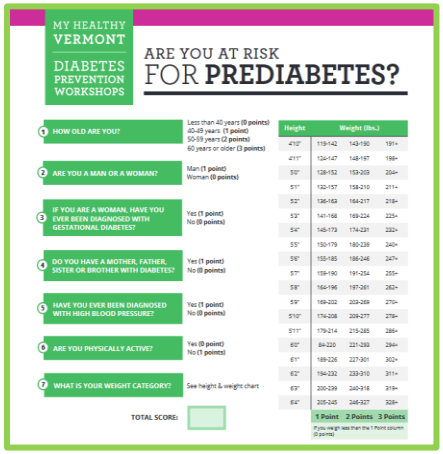


Source: Vermont Health Systems Quality Improvement Assessment (VHSQIA), 2022

Vermont EHR Examples:

Problem List: Gifford Health Care improved providers' use of the problem list through targeted education and guidance from the diabetes team, resulting in consistently higher utilization.

Screening: SASH (Support and Services at Home) integrated the prediabetes risk test into its population health system. Captured in the annual Comprehensive Health Assessment and system fields, this has strengthened care coordination within participants' healthy living plans.



Reports and Alerts:

Northeastern Vermont Regional Hospital worked with the Data Analytics department to generate a report identifying patients with prediabetes, enabling outreach via patient portals and mailings for the Diabetes Prevention Program.

The Northern Tier Center for Health developed an EHR sidebar alerting clinical staff and providers to key diabetes care metrics (A1C, foot exam, eye exam), enhancing management through real-time prompts.

Self-Management and My Healthy Vermont (MHVT)

Self-management programs are vital for improving the quality of life for individuals with or at risk of diabetes, empowering them with knowledge and confidence to manage their health. My Healthy Vermont (MHVT) offers free workshops that help people living in Vermont prevent and manage chronic conditions, including prediabetes and type 2 diabetes. Led by experienced facilitators, the workshops focus on practical lifestyle changes, with participants reporting improvements in diabetes management and overall well-being.

Organizations funded by 1815 have worked to increase referrals, raise awareness, and remove participation barriers. Despite COVID-19 disruptions, workshops successfully transitioned to virtual formats, maintaining access to essential health education.

I. Referrals

Between July 2021 and June 2023, a total of 579 Vermonters at risk for diabetes enrolled in the Diabetes Prevention Program - *MHVT Data*

For this document, a referral is defined as a process in which an individual or patient is recommended for a specific clinical or community-based program or service, such as an MHVT. Referrals to MHVT can be made by a variety of health care providers, including physicians, nurse practitioners, physician assistants, registered nurses, midwives, diabetes educators, pharmacists, registered dietitian, nutritionists, dentists and community health workers. Integrating referrals into diabetes care protocols ensures broader access and consistent engagement.

Challenges to Consider

Limited provider awareness of MHVT and similar programs.

Inconsistent referral processes and low incentive to refer

Implementation Strategies

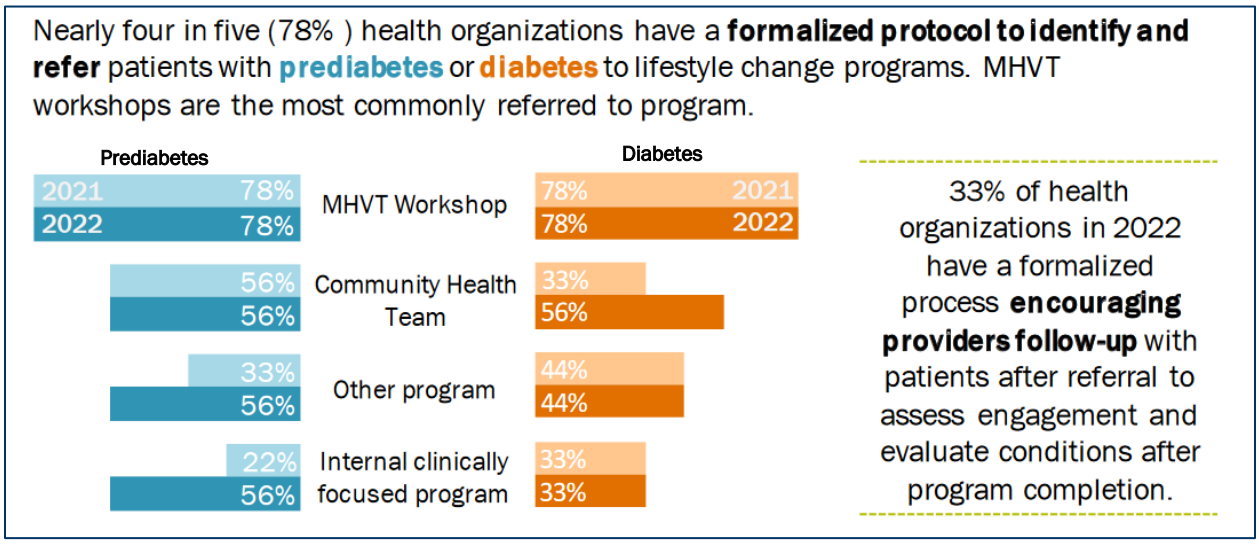
Assess: Identify gaps in referral pathways.

Standardize: Use EHRs to track referrals and identify eligible patients.

Educate: Provide training and resources to facilitate referrals, such as handouts for providers and presentations from the MHVT team, emphasizing the importance of support for individuals with diabetes.

Partner: Build health centers and community collaborations to support referrals to self-management. 💡 **Tip:** Utilize community health teams and other community meetings to promote the programs and provide referral information.

Follow-Up: Track participant engagement and program completion to support retention and outcomes. Connect with the MHVT Enrollment Specialist for additional information. ***Note:*** *This option was not available during the 1815-funded work.*



Sources: Vermont Health Systems Quality Improvement Assessment (VHSQIA), 2021-2022

Vermont Referral Examples

Staff Communication & Training: Community Health Centers of Burlington and Little Rivers Health Care kept clinical and patient-facing staff informed about upcoming MHVT workshops through weekly emails and calendar updates, including clear referral instructions. Gifford Health Care and SASH provided staff training on referral processes.

Direct Participant Outreach: Northeastern Vermont Regional Hospital, Battenkill Valley, and Northern Counties Health Care Inc. enhanced referrals by mailing information and using EHR patient portals to reach eligible participants.

Diabetes Self-Management Initiative: SASH paired participants with wellness nurses for regular monitoring and coaching.

II. Marketing & Outreach

Effective communication and marketing are essential for boosting engagement in self-management programs. While MHVT provides statewide marketing strategies and materials, participants respond best to trusted providers and support systems. Key components for increasing responsiveness include positive messaging, clear and relatable language and easy access to workshops.

Implementation Strategies

Patient Messaging: Use positive, understandable language that clarifies "self-management education" without classroom connotations.

Staff Education: Train all staff, including front desk personnel, provide talking points and integrate referral prompts in the EHR.

Visibility: Display posters and rack cards in high-traffic areas; download or request free materials from MHVT.

Digital Outreach: Partner with marketing specialists to enhance website and social media content.

Challenges to Consider

Inconsistent messaging across providers and offices.

Difficulty leveraging organizational platforms (e.g., websites, social media) due to functionality or competing priorities.

Vermont Examples

Posters and materials: 1815-funded organizations displayed prediabetes risk screening posters in waiting rooms and provided direct MHVT website links. Community health teams distributed flyers at health fairs, grocery stores, pharmacies, dental clinics and community centers.

Oral Health Integration: Community Health Centers of Burlington and Northern Counties Health Care Inc. created a bi-directional referral system linking dental care screenings to MHVT referral and medical follow-up, ensuring participants identified as at risk for prediabetes receive appropriate care.

III. Addressing Barriers to Participation

Participation in MHVT has been shown to improve health outcomes, including lowering A1C and systolic blood pressure, and reducing medication use and hospitalizations. Yet, barriers such as technology literacy, internet connectivity, transportation, scheduling, language, and health literacy can limit access, particularly for older adults and rural populations.

Implementation Strategies

Individualized Support: Recognize each patient's unique barriers and provide tailored assistance, potentially through Community Health Workers, with regular check-ins.

- Technology & Digital Access: Provide loaner devices (e.g., tablets) or tech support for virtual programs. Offer hybrid options: combine in-person sessions with online participation. Conduct brief tutorials for using telehealth platforms or online workshops.
- Internet Connectivity: Host sessions in locations with reliable Wi-Fi, such as community centers or libraries. Provide downloadable materials for offline use.
- Transportation and Location: Offer workshops at accessible community sites. Partner with local transportation services or provide travel vouchers.
- Scheduling and Time Constraints: Offer sessions at multiple times, including evenings or weekends. Allow flexible attendance or asynchronous content for virtual programs.
- Language and Cultural Barriers: Provide translated materials and interpretation services. Use culturally relevant examples and visual aids to enhance understanding.
- Health Literacy: Use plain language, visuals, teach-back methods, and reminders to reinforce learning. Develop interactive materials to empower participants to apply self-care skills.

Incentives: Offer supports such as food vouchers, gas cards, or connections to local food shelves to encourage participation. 💡 **Tip:** If unable to provide incentives, partner with local organizations to assist in providing supportive resources (food shelves, hospitals, wellness programs).

Vermont Examples

Technology Access: SASH expanded access to health and social opportunities through technology, launching a tablet computer loaner program and creating microlearning videos on prediabetes, diabetes, cholesterol and blood pressure. These videos are shared with participants individually and in groups by staff. They also piloted hybrid sessions in SASH common spaces, connecting small groups virtually to facilitators statewide, improving access for participants with limited technology or transportation options.

Food Access: Gifford Health Care partnered with the Vermont Foodbank to distribute food packages to participants in the Diabetes Prevention Program.

Reducing Health Disparities in Diabetes Care

Diabetes care must be tailored to individual needs, provider expertise, and community resources. In Vermont, some populations face disproportionate impacts and limited access to prevention and management services. Addressing health disparities and considering social determinants of health (SDOH) are critical priorities. The COVID-19 pandemic underscored existing inequities in diabetes care, prompting funded organizations to implement tailored health equity interventions and provide lessons for broader application.

I. Organizational Level Strategies

Transforming an organization's culture to prioritize health equity and address disparities requires strategic commitment, leadership engagement and long-term investment.

Implementation Strategies

Leadership Engagement: Make health equity a strategic priority, review policies and care processes, and collaborate with state and community partners.

Staffing & Training: Integrate community health workers to support patients and provide training on implicit bias and health equity to improve patient-provider interactions.

Data Collection & Quality Improvement: Collaborate with IT to identify disparities using population-level data, focusing on age, sex, race/ethnicity, disability, and LGBTQIA+ status. Develop referral pathways linking healthcare and social services and target quality improvement efforts toward marginalized populations.

Assess Social Determinants: Screen for SDOH using standardized tools to identify barriers and determine referrals.

Challenges to Consider

Limited leadership support for policy changes.

Staff frustration and insufficient training in caring for diverse populations.

Financial constraints and difficulty collecting data on small or marginalized populations.

Vermont Examples

Systems and Data Collection: EHR and population health platforms used to identify patients overdue for A1C testing, with reports segmented by insurance, age, race, and gender for targeted outreach.

Screening: Tools such as Hunger Vital Signs (food insecurity) and PRAPARE (social determinants of health) integrated into several 1815-funded organizational protocols and EHRs to better address patient needs.

Health Literacy: SASH integrated health literacy screening into their participant health assessment and hosted various sessions to support staff in addressing individuals with greater needs.

"Through our work in the 1815 grant, we have focused on patients at greatest risk of developing disease and those with higher disease burden who face barriers in management of chronic disease." -Community Health Centers of Burlington

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II. Individual Level Strategies

Care teams should consider patients' social context—including food insecurity, housing, employment, rural location, health literacy, and insurance—when making treatment decisions and evaluating outcomes for those with or at risk for diabetes.

Implementation Strategies

Support Health Literacy: Use visuals, teach-back, reminders, and culturally appropriate materials to reinforce nutrition and self-care skills.

Language & Communication: Offer interpretation services or digital translation tools; involve family members when appropriate. 💡 **Tip:** Check out the Vermont Language Justice "What is Diabetes" video, translated into 18 different languages.

Medication Management: Include a pharmacist on the care team to monitor adherence and address cost-related barriers.

Technology Access: Identify and address barriers to diabetes technology (e.g., Continuous Glucose Monitoring (CGM) and telehealth).

Patient Empowerment: Provide templates or tools to help patients communicate with providers, advocate for their care and actively manage diabetes.

Follow-Up & Monitoring: Conduct regular check-ins to track progress, address challenges and reinforce self-management strategies.

Challenges to Consider

Limited community resources for patients with social risk factors.

Lack of trust with healthcare providers and social services.

Low health literacy affecting diabetes knowledge and self-care.

Inequities due to medication costs and limited access.

Vermont Examples

Patient Support: The Little Rivers Health Center expanded its Chronic Care Management (CCM) program and worked with patients to address barriers to financial support for medical services and assisted patients in overcoming those barriers.

Empowerment: SASH created a communication template to help participants advocate for their diabetes care and improve self-management.

Access to CGM: The Gifford Health Care Diabetes Quality Improvement Team increased access to CGM by addressing financial barriers and tracked pre- and post-CGM A1C outcomes, demonstrating improved diabetes management.

"There are many factors outside of an office visit that impact a person's ability to manage diabetes, and taking the time to identify and help mitigate those factors can sometimes be just as important as the clinical interventions." Gifford Health Care

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Additional Information and Resources

American Diabetes Association (ADA) Standards of Care *Updated in 2025:
https://professional.diabetes.org/standards-of-care

BiState Primary Care Association

https://bistatepca.org/

Centers for Disease Control and Prevention (CDC) Diabetes Pages:

https://www.cdc.gov/diabetes/index.html

Quality Improvement Tools:

Agency for Healthcare Research & Quality:

https://www.ahrq.gov/evidencenow/tools/qi-essentials-toolkit.html

Vermont 2-1-1:

http://www.vermont211.org/

Vermont Department of Health Diabetes Program:
https://www.healthvermont.gov/wellness/diabetes

Vermont Diabetes Data

- Diabetes Surveillance: https://www.healthvermont.gov/health-statistics-vital-records/surveillance-reporting-topic/diabetes
- Healthy Vermonters 2030 Scorecard: https://embed.clearimpact.com/Scorecard/Embed/84424

Vermont Self-Management:

Take action to prevent or manage diabetes with My Healthy VT https://www.myhealthyvt.org