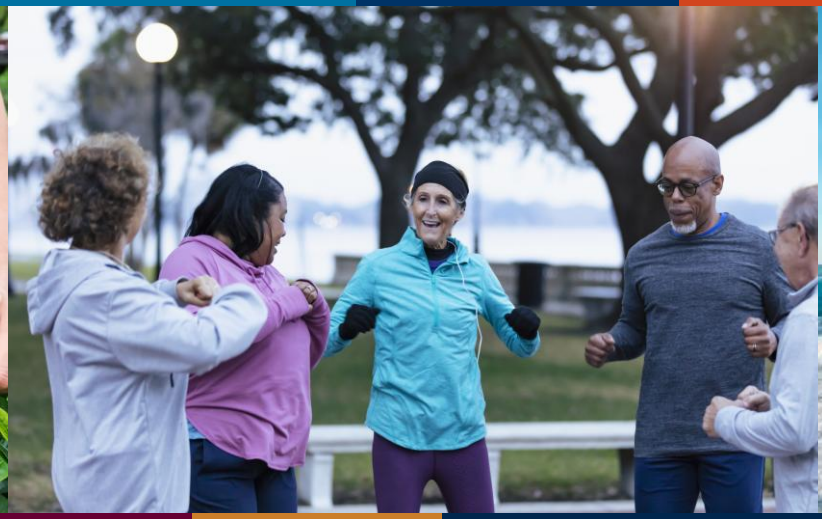
Vermont Diabetes State Plan

Reducing the burden of diabetes in Vermont.

2025 – 2030



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Introduction

The Vermont Diabetes State Plan 2025-2030 represents a collaborative five-year vision aimed at enhancing diabetes care and outcomes across the state. Recognizing the importance of a unified approach, this plan seeks to leverage Vermont's unique strengths, including its strong partnerships among public health entities, clinical and community organizations, and the residents themselves. As disparities in health care continue to widen, the urgency for coordinated, intentional, equity-centered approaches has never been greater. The Vermont Department of Health is well positioned to bring together partners from across the state to establish shared priorities, approaches, and actions that will guide these efforts. With facilitation support from Professional Data Analysts, the Vermont Department of Health and its partners embarked on a comprehensive process to develop this plan.

In addition to strategic goals, strategies, and activities intended to reduce the burden of diabetes in Vermont, this plan includes quotes from people in Vermont who participated in the diabetes lived experience story collection project. The project involved virtual listening sessions and a written story collection survey with 23 people, ranging in age and length of diabetes diagnosis. These quotes help bring lived experience into the plan and its implementation. Quotes included in the plan were minorly edited for grammar and readability. See below how quotes appear throughout the plan.

> **Quote describing lived experience.**
> *- Person in Vermont with Diabetes*

If you need help accessing or understanding this information, contact AHS.VDHHPDPDiabetesTeam@vermont.gov.

Table of Contents

Selecting any of the sections below will bring you to that specific content area in the plan.

About the Vermont Diabetes State Plan

The development of the plan was funded by the Centers for Disease Control and Prevention and involved a wide array of partners from across the state. The Vermont Department of Health convened statewide leaders, providers, allied health professionals, and others to gather input and feedback over nearly two years. This inclusive process featured surveys, workgroups with partners across the state, and listening sessions with Vermont residents living with diabetes, ensuring that the plan reflects diverse perspectives, lived experiences, and recognizes geographic disparities within the state.

The plan outlines strategies to enhance diabetes care in three key areas:

1. **Raising awareness and promoting diabetes programs and services**
2. **Improving screening and referrals for prediabetes and diabetes**
3. **Expanding access to and utilization of diabetes programs and services**

A variety of strategies and activities support these key areas, allowing Vermont's diabetes partners across community, clinical, and governmental sectors to contribute to the shared vision.

Plan Development Timeline

January 2024

Initial Planning
Initial meetings with the Diabetes Prevention Coalition to inform the process and gather initial input.

Partner Survey 1
Identification of priorities and partners interested in being involved.

Work Group Meetings 1
Goal areas defined and strategies development started.

Work Group Meetings 2
Strategies defined and activities identified.

Partner Survey 2
Input gathered on draft content.

Work Group Meetings 3
Strategies and activities finalized.

Diabetes Lived Experience Story Collection Project

Plan finalized

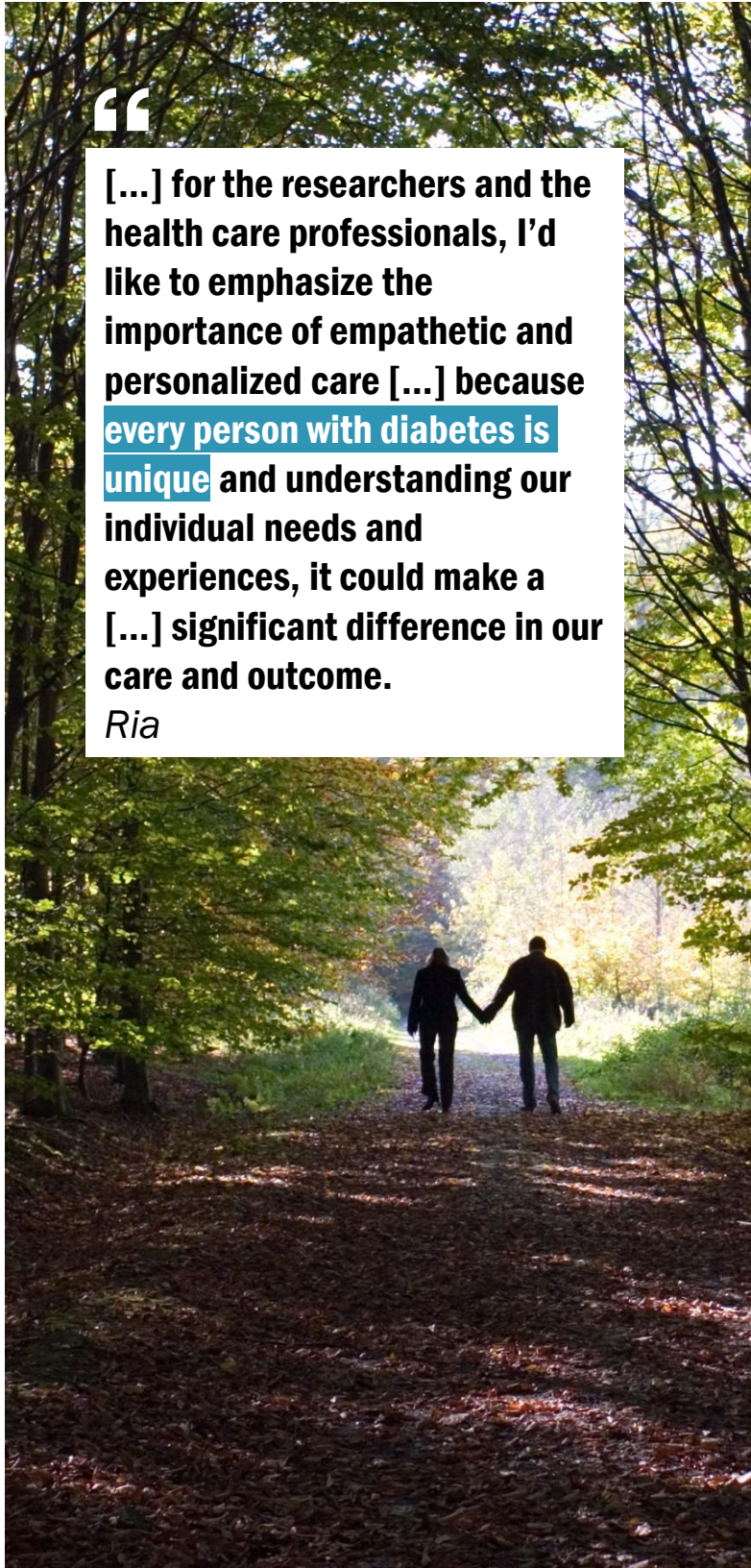
June 2026

While the plan offers a comprehensive framework for improving diabetes care, it also acknowledges its limitations. The plan strategies cannot directly address coverage of health care providers, reduce health care costs, improve access to insurance coverage, or resolve the root causes of health disparities such as low income, geographic region, and housing availability. However, by offering collective strategies and specific actions, the plan aims to strengthen Vermont's capacity to improve outcomes and reduce disparities.

A core aspect of the plan is its recognition of the impact of stigma and bias in diabetes care. Stigma, often stemming from misconceptions about diabetes, can originate from health care providers, family members, peers, and society, leading to negative attitudes and behaviors toward individuals with the condition. This plan acknowledges the challenges and stress of managing diabetes and the feelings of shame and guilt that can arise from bias or discrimination. Dismantling bias toward diabetes is deemed vital for improving outcomes, and the plan seeks to address these issues as part of its comprehensive approach to diabetes care in Vermont.

Over the next five years, State Plan success will be measured by increased screening rates, stronger referral pathways, expanded participation in diabetes prevention and self-management programs, and ultimately, reductions in diabetes-related hospitalizations, complications, and premature death. By centering equity and harnessing Vermont’s collaborative strengths, this plan creates a roadmap for Vermont organizations concerned about diabetes to work together toward better outcomes for all people in Vermont at risk for or living with diabetes.

A variety of activities support these strategies, allowing Vermont's diabetes partners across community, clinical, and governmental sectors to contribute to the shared vision.



> **[…] for the researchers and the health care professionals, I’d like to emphasize the importance of empathetic and personalized care […] because every person with diabetes is unique and understanding our individual needs and experiences, it could make a […] significant difference in our care and outcome.**
> *Ria*

Diabetes in Vermont

Diabetes remains a significant health concern in Vermont, as it does across the United States.

Type 2 diabetes is a leading cause of morbidity and mortality, influenced by environmental factors, access to equitable care, and genetics. Lifestyle factors, such as access to affordable nutritious food, opportunities for physical activity, and tobacco use, are often shaped by social determinants of health and can increase the risk of developing diabetes or prediabetes, leading to poor health outcomes.

Prediabetes, characterized by elevated blood sugar levels not yet high enough for a diabetes diagnosis, presents early health risks, underscoring the need for timely intervention.

Gestational diabetes, which occurs during pregnancy, poses risks for both pregnancy complications and future diabetes development.

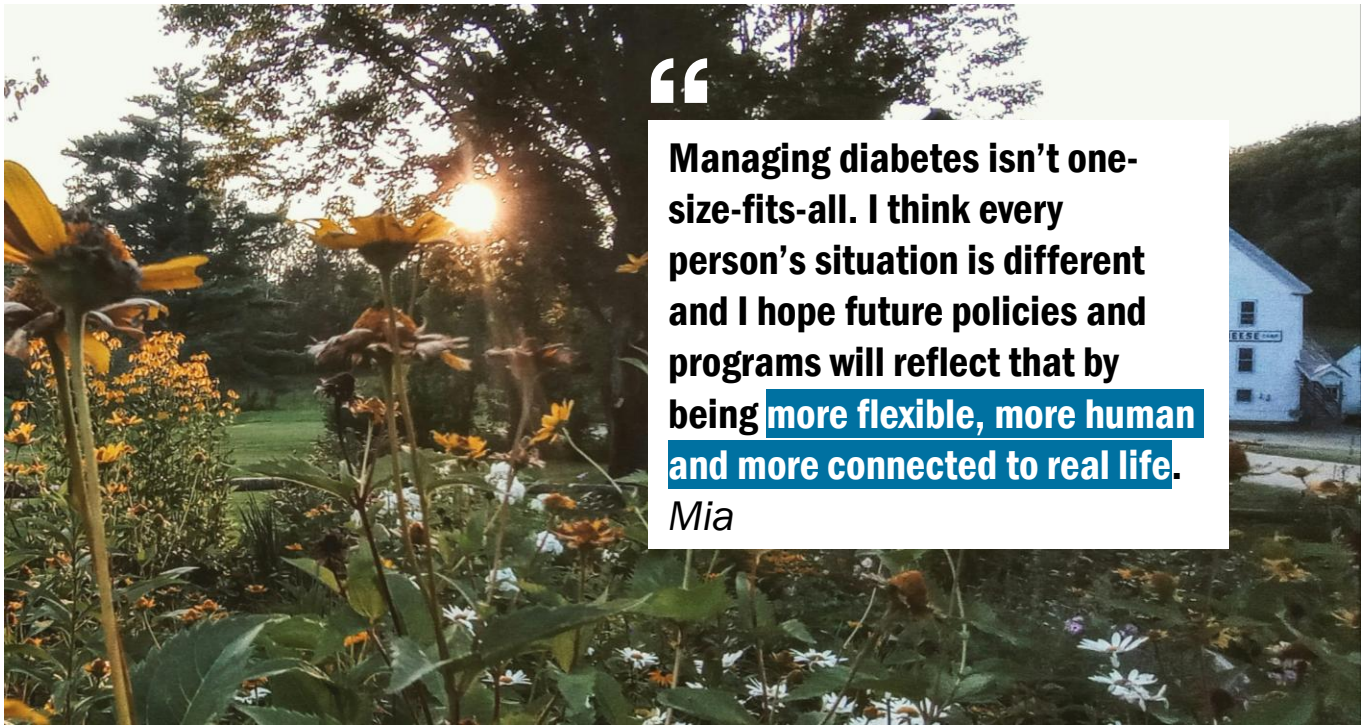
In Vermont, approximately 10% of adults have been diagnosed with prediabetes, and 8% of births in 2023 were to individuals with gestational diabetes. The prevalence of diagnosed diabetes among Vermont adults stands at 9%, lower than the national average, yet the rates of hospital discharges and emergency department visits for diabetes-related issues have been rising.

Visit the diabetes surveillance webpage for the most up to date data on diabetes in Vermont.

47,200 **(10%) of adults have been diagnosed with prediabetes.** (BRFSS, 2023)

394 **(8%) of births were to individuals with gestational diabetes.** (VT Vital Statistics, 2023)

49,300 **(9%) of adults have been diagnosed with diabetes.** (BRFSS, 2023)



> **Managing diabetes isn't one-size-fits-all. I think every person's situation is different and I hope future policies and programs will reflect that by being more flexible, more human and more connected to real life.**
> *Mia*

Measuring Progress

There are four overarching indicators intended to measure overall progress towards reducing the burden of diabetes in Vermont. These indicators come from consistently available statewide surveillance data that multiple plan strategies and activities are intended to improve.

In addition to these overarching indicators, each of three goal areas include indicators and measures to determine progress for each strategy. Click on the goal area below to view each goal area's specific indicators.

Awareness & Promotion

Screening & Referral

Access & Utilization

The evaluation of the Vermont Diabetes State Plan 2025-2030 will be led by the Vermont Department of Health, with support from partners. The evaluation will track progress on the overarching and goal area specific indicators, as well as implementation of strategies and activities by the Vermont Department of Health and partners. Evaluation of the plan is intended to provide accountability and data-driven recommendations. All evaluation planning and implementation efforts will follow CDC's six-step Framework for Evaluation in Public Health, incorporating the needs and perspectives of partners during each step of the process.

Overarching Indicators

Increase the percent of adults diagnosed with prediabetes who have ever participated in a lifestyle change program to improve their health or prevent diabetes.

Source: VT BRFSS

Increase the percent of adults diagnosed with diabetes who have ever attended diabetes self-management education.*

Source: VT BRFSS

Increase the rate of primary care visits among adults with prediabetes and diabetes.

Source: VT BRFSS

Decrease the rate of deaths for any cause among adults 18 and older with diabetes.*

Source: Vermont Vital Statistics

*This is a Healthy Vermonters 2030 measure. See the HV2030 Performance Scorecard for additional details.

BRFSS: Behavioral Risk Factor Surveillance System

Goal Areas, Strategies, & Activities

Each of the three goals areas – **Awareness & Promotion**, **Screening & Referral**, and **Access & Utilization** – have an overarching goal area statement, three strategies, and proposed activities. Below are definitions of key terms used throughout the plan.

Goals

Broad, overarching areas for addressing the burden of diabetes in Vermont.

Strategies

Steps towards achieving goals.

Activities

Specific activities toward strategies based on research and evidence-based practices.

☐ Proposed activities are listed under each strategy.

✓ Examples of activities that are currently being implemented or were implemented recently by the Vermont Department of Health and their partners are also listed as references on the right side of each strategy page. These examples are not comprehensive.

Populations of Focus

Populations more likely to be affected by diabetes than others due to social, environmental, and economic disadvantage. Key populations of focus in the Vermont Diabetes State Plan include:

- People with disabilities
- People with low socioeconomic status
- People over the age of 65
- People who live in rural areas

Those implementing the plan are encouraged to consider how activities will support diabetes prevention and management among these populations in particular.

Awareness & Promotion
Increase awareness, knowledge, and reduction of the risk factors for prediabetes, diabetes and gestational diabetes among the general public, health care professionals, community-based organizations and worksites.

Screening & Referral
Increase the number of people in Vermont who are screened for prediabetes, diabetes, and related risk factors and referred to available resources.

Access & Utilization
Sustainably expand coverage, access and utilization of high quality, accessible, culturally relevant and evidence-based diabetes prevention programs and management services.

Awareness & Promotion

Increase awareness, knowledge and reduction of the risk factors for prediabetes, diabetes and gestational diabetes among the general public, health care professionals, community-based organizations and worksites.

Strategies

1. Promote coordinated, community-level diabetes prevention and management efforts through tailored and consistent messaging, education, policies and funding.

2. Dismantle diabetes stigma by increasing awareness of bias and associated harms and ensuring that positive and inclusive language is used in all diabetes communications and resources.

3. Build partnerships with community agencies and allied health professionals to increase awareness of diabetes risk for anyone with a history of gestational diabetes and share risk reduction strategies and referral options.

Having diabetes can consume much of a person's physical time as well as mental energy and sense of self-efficacy. Even if manageable, it can impact overall health and wellbeing. People in Vermont with diabetes highlight for us that there is a need to acknowledge and address the mental and emotional toll of diabetes when increasing awareness, knowledge, and reduction of the risk factors.

> **My diabetes can be very stressful and emotionally challenging and it's essential to have a support system in place.**
>
> **I need to constantly monitor by blood sugar levels. I need to constantly plan my meals. I need to constantly adjust my activities to manage my diabetes. It has also significantly impacted my social life.**
> *Ria*

> **[...] managing diabetes has really taught me strength, discipline and resilience. I have come to see it not just as a condition I manage, but as a reminder to care for myself deeply and intentionally.**
> *Pieter*

> **I struggle continually with this disease.**
> *Christine*

> **[...] most people out there don't know how exhausting and how mentally challenging [and] draining [diabetes] is.**
> *Clef*

Strategy 1

Promote coordinated, community-level diabetes prevention and management efforts through tailored and consistent messaging, education, policies and funding.

- ☐ Collaborate with state agencies and community organizations across Vermont to support the shared vision of the State Health Improvement Plan, with a focus on efforts that impact diabetes prevention and care.
- ☐ Support efforts to increase accessibility and affordability of quality health care coverage and effective pharmaceuticals to broaden the range of covered health care, including durable medical equipment.
- ☐ Provide ongoing training and support on diabetes prevention and management opportunities for providers, care navigators, nurses and other patient care professionals.
- ☐ Develop and incorporate messaging and education on the mental and emotional burden of diabetes as an essential element of diabetes prevention and management.
- ☐ Provide approachable guidance on exercise, emphasizing balance and bio-movements, push, pull, squat, etc.
- ☐ Disseminate messages at community locations such as libraries and schools and online platforms such as Front Porch Forum.
- ☐ Focus efforts to share and improve access to strategies and social supports at the community-level to address structural barriers.

Examples of recent or current activities

- ✓ Blueprint for Health Community Health Teams, Southwestern Vermont Medical Center, and other organizations support people who need additional resources to address health-related social needs.
- ✓ Consistent funding for My Healthy VT is provided under Medicaid 1115 waiver (anticipated through 2027) to provide free access to diabetes prevention and management workshops to all people living in Vermont.
- ✓ Support and Services at Home provides ongoing training to its wellness nurse staff on diabetes prevention and management for its constituents.
- ✓ The Vermont Department of Health Diabetes Program advertises diabetes prevention and management resources to private health systems and the general public in collaboration with other chronic disease programs, such as tobacco and cardiovascular health, to generate awareness.

Strategy 2

Dismantle diabetes stigma by increasing awareness of bias and associated harms and ensuring that positive and inclusive language is used in all diabetes communications and resources.

- ☐ Provide educational opportunities for health care providers on the impact of strength-based, motivational interviewing and empowering language when speaking about diabetes prevention and management. Include a focus on health disparities that impact diabetes management and how to support patients more effectively during clinical counseling.
- ☐ Revise patient materials to send messages that focus on physiology, empowerment and strengths rather than stigma, blame or judgement.
- ☐ Conduct a statewide media campaign to amplify messages that focus on physiology, empowerment and strengths rather than stigma, blame or judgement.
- ☐ Meaningfully engage community members when developing materials and messages.
- ☐ Continuously review and update Learning to Live Well with Diabetes resources.

Examples of recent or current activities

- ✓ With support from the Vermont Department of Health, the Vermont Language Justice Project created videos on diabetes management that are free of biased language, culturally appropriate and available in many languages.
- ✓ All Vermont Department of Health website language was updated to remove biased language, such as language related to weight, food intake, age, abilities, etc. and further promote inclusivity by using accessible language and formatting.
- ✓ The Vermont Department of Health, with support from partners such as the University of Vermont, Vermont Department of Mental Health, and various health practitioners, offers ongoing education and facilitated discussion on the harms of weight bias and importance of weight inclusivity to public health professionals.

Strategy 3

Build partnerships with community agencies and allied health professionals to increase awareness of diabetes risk for anyone with a history of gestational diabetes and share risk reduction strategies and referral options.

- ☐ Develop culturally appropriate educational materials that use plain language to communicate diabetes risk and reduction and disseminate to people diagnosed with gestational diabetes and providers who care for them.
- ☐ Strategically share surveillance data briefs and findings with providers and the public.
- ☐ Ensure educational materials have a welcoming/positive tone, “the benefits of knowing your risk”, for example.

Examples of recent or current activities

- ✓ My Healthy VT diabetes prevention program is available to adults 18 and older and promoted as an evidence-based referral option.
- ✓ My Healthy VT is working with partners from the Rutland area to host a diabetes prevention program workshop for people who have been diagnosed with gestational diabetes.
- ✓ The Vermont Department of Health expanded availability of data on gestational diabetes.

Measuring Progress in Awareness & Promotion

The following page outlines indicators and measures to determine progress for each strategy, including *data sources* and *availability*.

Strategies	What indicators and measures will let us know when progress is made?
1 Promote coordinated, community-level diabetes prevention and management efforts through tailored and consistent messaging, education, policies, and funding.	**Increase the frequency of messages disseminated about diabetes prevention and management in community spaces.** 1. Average number of community focused communications (emails, presentations, fliers, event tabling) sent or held per month about diabetes prevention and management topics by Vermont Department of Health staff and partner organizations *(Vermont Department of Health program records, annual)*.
2 Dismantle diabetes stigma by increasing awareness of bias and associated harms and ensuring that positive and inclusive language is used in all diabetes communications and resources.	**Increase the availability of person-centered patient resources or materials that avoid concepts and language that could stigmatize having diabetes.** 1. Number of revised or redesigned patient materials shared in the last calendar year that use non-stigmatizing, person-centered language related to diabetes. *(new Vermont Department of Health survey, annual)*.
3 Build partnerships with community agencies and allied health professionals to increase awareness of diabetes risk for anyone with a history of gestational diabetes and share risk reduction strategies and referral options.	**Broaden the dissemination of diabetes surveillance data to target audiences.** 1. Number of health care providers that data products are directly disseminated to through regular Vermont Department of Health Diabetes Program or state partner communications *(Vermont Department of Health program records, annual)*. 2. Number of social media post interactions or data product link clicks *(Vermont Department of Health social media and web link clicks, annually).*

Screening & Referral

Increase the number of people in Vermont who are screened for prediabetes, diabetes, and related risk factors and referred to available resources.

Strategies

1. Expand the use of tools, including electronic health records and other standardized tools, to identify risk factors for prediabetes and diabetes and ensure timely and appropriate screening and diagnosis.

2. Improve and expand the role of all patient-facing support staff, including nontraditional staff, in screening for prediabetes, diabetes and associated risk factors, as well as in referring patients to diabetes prevention and management programs within their scope of practice (e.g., questionnaire, lab order).

3. Establish and strengthen health care referral policies and practices to efficiently connect people to programs/services for diabetes prevention and management, health-related social needs (e.g., healthy food, housing, transportation) and mental health.

Vermont residents with diabetes shared that they want and need opportunities to continuously learn about diabetes and ways to manage it, as well as to connect with others with similar experiences.

> **[…] but overall, I've stayed committed to keeping my blood sugar within safe range, attending my checkups and learning more about what my body needs. So, it's not always easy, but I've come a long way from where I started and […] I'm kind of proud of the progress I've made.**
> *Pieter*

> **[…] managing diabetes has been a journey of constant learning and adjustment.**
> *Mia*

> **I wish [my provider] had taken more time to help me understand patterns in my readings or referred me to a diabetes educator.**
>
> **Since things are always changing, sometimes it feel like once you're diagnosed, you're left to figure it out on your own.**
>
> **[Something that would help me better manage my diabetes is] peer groups where people with diabetes can actually share tips and experiences […] sometimes just hearing how others handle challenges makes a difference.**
> *John*

> **[A big success in managing my diabetes is] belonging to an on-line support group led by a certified diabetes educator where I am able to get moral support and stay up to date on diabetes issues.**
> *Dale*

Strategy 1

Expand the use of tools, including electronic health records and other standardized tools, to identify risk factors for prediabetes and diabetes and ensure timely and appropriate screening and diagnosis.

- ☐ Partner with billing and coding professionals to add or better capture measures related to risk factors and diabetes standard of care in electronic health records.
- ☐ Promote clinical adoption of standardized risk screening tools that lead to enhanced diabetes and pre-diabetes screening and diagnosis.
- ☐ Develop trainings, as needed, on the use of standardized tools for identifying risk factors for prediabetes and diabetes.

Examples of recent or current activities

- ✓ Advocacy and funding from Bistate Primary Care Association is leveraged to support electronic health record quality improvement strategies for Federally Qualified Health Centers.
- ✓ Support and Services at Home screens participants for health-related social needs and documents results in Support and Services at Home population health participant registry (current iteration is called "FamCare").
- ✓ The Vermont Department of Health conducted a statewide, multi-media outreach campaign in 2022 to encourage people to take the prediabetes risk assessment on My Healthy VT's website.

Strategy 2

Improve and expand the role of all patient-facing support staff, including nontraditional staff, in screening for prediabetes, diabetes, and associated risk factors, as well as in referring patients to diabetes prevention and management programs within their scope of practice (e.g., questionnaire, lab order).

- ☐ Develop or expand trainings and resources for care teams on screening and self-management strategies, including referrals to various programs and how to use principles of motivational interviewing to discuss referrals with patients to diabetes prevention and management programs.
- ☐ Promote integration of Community Health Workers into health care and community-based organizations to support screening for prediabetes, diabetes, and related risk factors and referrals to programs and services.
- ☐ Provide culturally appropriate print and promotional materials for patient waiting rooms, communications, etc. to raise patient awareness focused on the desired overall change (e.g., know your risk for diabetes, talk with [person] about how we can help).
- ☐ Allow for Public Health nurses to be trained in screening practices and have testing materials available so they can screen for diabetes at community vaccine clinics and other community events.

Examples of recent or current activities

- ✓ The Vermont Association of Community Health Workers was created and launched in 2024.
- ✓ Statewide monthly community health worker newsletter from the Vermont Department of Health includes My Healthy VT information, diabetes training (as available), etc.
- ✓ Referral mechanisms for My Healthy VT diabetes prevention and management workshops and diabetes self-management education and support (DSMES).
- ✓ Blueprint for Health implemented the Community Health Team Expansion Model. Vermont legislature authorized a 2-year (2023-2025) Community Health Team Expansion Pilot Program under the Blueprint for Health to increase capacity to provide screening, brief intervention, treatment and navigation to and coordination of services.
- ✓ Referral to self-management programs is often a role of community health teams.
- ✓ Support and Services at Home utilizes Wellness Nurses and Community Health Workers for screening and referring as part of their protocol.

Strategy 3

Establish and strengthen health care referral policies and practices to efficiently connect people to programs/services for diabetes prevention and management, health-related social needs (e.g., healthy food, housing, transportation), and mental health.

- ☐ Expand opportunities to recognize and elevate providers and practices who make referrals.
- ☐ Establish bidirectional and closed loop referral systems to program and resources for diabetes prevention and management, health-related social needs, and mental health.
- ☐ Provide a template policy for practices that can be modified by location based on location specific information.
- ☐ Create a standardized triage tool for determining which self-management tool is best for a patient based on their readiness, motivation, transportation, internet access, etc.
- ☐ Create a list of best practices for internal patient-centered medical home self-management programs to ensure programs meet the needs of each individual.
- ☐ Train providers about the best way to make a referral, including discussing referral options with patients and determining interest in a referral before referring.
- ☐ Expand the integration of health-related social needs screening tools into electronic health records.

Examples of recent or current activities

- ✓ Quality improvement professionals like Bistate Primary Care Association, Vermont Program for Quality in Health Care and Blueprint for Health are working to improve provider office flows, efficiency and clinical processes with a focus on improving health indicators.
- ✓ A resources page is maintained on My Healthy VT for health-related social needs supports.
- ✓ Some health centers are working with findhelp.org to develop a more streamlined way to refer to community agencies in their area and promote bidirectional communication via the electronic medical record.
- ✓ Referrals are made, as appropriate, for external services during My Healthy VT registration.
- ✓ The Vermont Department of Health Diabetes Program is developing and revising the resources page on the Health Department diabetes webpage.
- ✓ Various health centers in Vermont refer and connect qualifying patients at risk for chronic diseases with food access programs (e.g., Community Support Agriculture subscriptions, Food Farmacy).

Strategy 3 continued

- ☐ Explore opportunities to utilize health information technology, such as electronic health record systems to assist in making referrals such as prompts, alerts, reminders, or screening and referral algorithms.
- ☐ Educate providers about VT 211 resources.
- ☐ Distribute a one-page reference guide to local offices.
- ☐ Refer individuals for behavioral health and other co-morbid conditions for pre-diabetes and diabetes such as referrals to Area Agencies on Aging for assistance with determining insurance coverage for mental health services and counseling.
- ☐ Expand or scale up programs that connect qualified individuals at risk for chronic conditions such as diabetes with services intended to mitigate chronic health conditions (i.e., Medically tailored meals, Food Farmacy).

Measuring Progress in Screening & Referral

The following page outlines indicators and measures to determine progress for each strategy, including *data sources* and *availability*.

Strategies	What indicators and measures will let us know when progress is made?
1 Expand the use of tools, including electronic health records and other standardized tools, to identify risk factors for prediabetes and diabetes and ensure timely and appropriate screening and diagnosis.	**Increase access to screening for those at risk for diabetes.** 1. Rate of blood sugar screening in the last calendar year among those diagnosed with prediabetes *(BRFSS, every other year)*.
2 Improve and expand the role of all patient-facing support staff, including nontraditional staff, in screening for prediabetes, diabetes and associated risk factors, as well as in referring patients to diabetes prevention and management programs within their scope of practice (e.g., questionnaire, lab order).	**Increase training on prediabetes and diabetes screening practices.** 1. Number of clinical and non-clinical support staff (i.e., public health nurses, community health workers) trained in prediabetes and diabetes screening practices *(new Vermont Department of Health survey, annual)*.
3 Establish and strengthen health care referral policies and practices to efficiently connect people to programs/services for diabetes prevention and management, health-related social needs (e.g., healthy food, housing, transportation) and mental health.	**Increase the number of people with diabetes who complete diabetes education from a health care provider referral source.** 1. Number of My Healthy VT diabetes prevention and management workshop completers who were referred from a health care provider referral source *(My Healthy VT, annual)*.

Access & Utilization

Sustainably expand coverage, access, and utilization of high quality, accessible, culturally relevant and evidence-based diabetes prevention programs and management services.

Strategies

1. Adapt or tailor diabetes programs and services to reduce barriers, ensure statewide availability, and increase accessibility for all people in Vermont.

2. Integrate community health workers in the promotion of, referral to, and support of participants in My Healthy VT diabetes prevention and management programs and DSMES.

3. Remove barriers to providing diabetes care by expanding continuing education and other supports for health care providers.

Diabetes creates a financial burden. The cost of and access to medication, equipment or other resources can simultaneously facilitate and hinder a person's ability to manage their condition. People in Vermont with diabetes are asking for help to address access and use of diabetes support.

> **I do have health insurance, but it doesn't really cover everything. And there are certain things that I have to cover myself.**
> *Tabitha*

> **I've had to make [a] tough choice between what I need and what I can actually afford. [It] is stressful knowing that my health depends on things that aren't always financially accessible.**
> *Pieter*

> **[…] better access to affordable health care, medication and supplies would make a big difference because sometimes cost can be a barrier to staying consistent.**
>
> **I can manage my diabetes as long as I stay committed to the routine. […] There are definitely some days when it feels harder, though. Especially when life gets stressful. […] Overall I will say I feel confident in managing it long term with the right support, resources, and mindset.**
> *Mia*

Strategy 1

Adapt or tailor diabetes programs and services to reduce barriers, ensure statewide availability, and increase accessibility for all people in Vermont.

- ☐ Collaborate with and learn from other state health departments who modify DSMES for various groups and cultures.
- ☐ Connect with Vermont organizations and leaders (e.g., Association of Africans Living in Vermont, U.S. Committee for Refugees and Immigrants, community health workers, Cultural Brokers) about adapting curriculum to be more culturally appropriate.
- ☐ Explore sustainable partnerships with local community partners, such as libraries, to offer space for in-person/hybrid workshops and technological support to participants.
- ☐ Train DSMES service providers/diabetes self-management program workshop facilitators from various cultural/community backgrounds to increase appropriateness and accessibility for participants from those same backgrounds.
- ☐ Increase opportunities for local, in-person diabetes prevention and management programs.
- ☐ Create or identify an asynchronous educational opportunity tailored for people diagnosed with gestational diabetes.
- ☐ Train Registered Nurse Care Managers to be facilitators of My Healthy VT to offer in-house schedule programs.
- ☐ Expand the availability of support groups, health coaching, and other tools for managing diabetes statewide.

Examples of recent or current activities

- ✓ The Vermont Department of Health created a diabetes overview video and how to access diabetes prevention program (DPP) and treatment translated into 18 languages.
- ✓ The Vermont Department of Health is planning to invite a community health worker working with refugee populations to be trained to lead DPP and review content to ensure appropriateness and accessibility.
- ✓ There is outreach to Vermont employers regarding offering My Healthy VT workshops to employees as part of worksite wellness offerings.

Strategy 2

Integrate community health workers in the promotion of, referral to, and support of participants in My Healthy VT diabetes prevention and management programs and DSMES.

- ☐ Identify what specific needs community health workers have for better supporting people with diabetes or at risk of developing diabetes.
- ☐ Identify role(s) or actions for community health workers related to My Healthy VT programming.
- ☐ Explore partnerships to train community health workers from populations not traditionally served by My Healthy VT to deliver workshops and give feedback on improving curriculum to make it more accessible and appropriate.
- ☐ Coordinate with community health workers to support updating documents or supplements to resources to meet the needs of the populations served.
- ☐ Host focus groups with community health workers to understand the needs of the populations they serve.
- ☐ Continue to explore sustainable funding for community health workers in collaboration with partner programs, organizations, and agencies.

Examples of recent or current activities

- ✓ My Healthy VT is promoted to community health workers, such as at the annual community health worker conference.
- ✓ North Star Health in Springfield trains community health workers in assisting people with diabetes with lifestyle modifications and engaging in care using a curriculum offered by the Association of Diabetes Care & Education Specialists.
- ✓ Routinely screening for social determinants of health in patients with diabetes and connecting them with community health workers, care coordinators, etc. to enhance access to relevant organization and community resources is happening statewide.
- ✓ Support and Services at Home directly enrolls individuals in My Healthy VT through community health workers.
- ✓ Blueprint for Health's Community Health Teams (CHT) Expansion Pilot increased community health worker staffing on community health teams.
- ✓ Promotion of My Healthy VT to community health workers, such as at the annual community health worker conference.

Strategy 3

Remove barriers to providing diabetes care by expanding continuing education and other supports for health care providers.

- ☐ Tailor regional outreach and education events (e.g., Lunch and Learn) to primary care offices and community spaces about My Healthy VT programs and referral processes, the American Diabetes Association guidelines app, and other community resources.
- ☐ Streamline My Healthy VT referrals via portal messages or other proven methods.
- ☐ Work to broadly de-stigmatize diabetes and diabetes care through provider education and supports.
- ☐ Strengthen statewide systems for ensuring access to care for women with diabetes who are pregnant.
- ☐ Partner with endocrinologists to provide diabetes-specific trainings for primary care providers.

Examples of recent or current activities

- ✓ My Healthy VT provider outreach specialists work within their catchment areas to connect with providers to facilitate awareness of and referrals to My Healthy VT.

Measuring Progress in Access & Utilization

The following page outlines indicators and measures to determine progress for each strategy, including *data sources* and *availability*.

Strategies	What indicators and measures will let us know when progress is made?
1 Adapt or tailor diabetes programs and services to reduce barriers, ensure statewide availability, and increase accessibility for all people in Vermont.	**Increase the proportion of Vermont adults with diagnosed diabetes who have participated in a lifestyle change or self-management program for diabetes.** 1. Rate of adults 18 and older with diagnosed diabetes who have ever taken a course or class in how to manage their diabetes *(BRFSS, every other even year)*. 2. Number of clinical- and community-based diabetes education and support programs in the state that have implemented at least one evidence-based modification to improve accessibility (e.g., available in multiple languages) *(new Vermont Department of Health survey, annual)*. 3. Number of accredited/recognized DSMES service providers available in Vermont *(American Diabetes Association/Association of Diabetes Care & Education Specialists, annual)*. 4. Number of facilitators *(My Healthy VT, annual)*.
2 Integrate community health workers in the promotion of, referral to, and support of participants in My Healthy VT diabetes prevention and management programs and DSMES.	**Increase the engagement of community health workers in diabetes self-management and support service delivery.** 1. Number of feedback sessions (e.g., focus groups, listening sessions) held with community health workers about serving people with diabetes, during the calendar year *(Vermont Department of Health program records, as available)*.
3 Remove barriers to providing diabetes care by expanding continuing education and other supports for health care providers.	**Improve clinical partner outreach to grow awareness of diabetes lifestyle change and self-management program benefits and referral processes among primary care practices.** 1. Number educational outreach events held during the last calendar year for primary care practice staff about DSMES benefits and referral processes *(My Healthy VT and new Vermont Department of Health survey, annual)*.

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A

Age Well
Alzheimer's Association Vermont Chapter

B

Barre Housing Authority
Battenkill Valley Health Center
Beauchamp & O'Rourke Pharmacy
Bi-State Primary Care Association
BlueCross and BlueShield Vermont
Brattleboro Memorial Hospital

C

Central Vermont Medical Center
Central Vermont Council on Aging
Champlain Housing Trust
Community Health Centers of the Rutland Region

E

Elderly Services Inc.
Evergreen Family Health Partners

G

Gifford Health Care
Grace Cottage Hospital
Grace Initiative Global

H

Healthcentric Advisors
Housing Trust of Rutland County

L

Little Rivers Health Care

M

Mountain Community Health
Mt. Ascutney Hospital and Health Center

N

North Country Primary Care
North Star Federally Qualified Health Center
Northeast Kingdom Council on Aging
Northeastern Vermont Regional Hospital
Community Connections
Northern Counties Health Care, Inc.
Northern Tier Center for Health
Northwestern Medical Center Pharmacy
Nourished Journey Nutrition Counseling and Doula Support, PLC

P

Primary Care Health Partners

R

Randolph Area Community Development Corporation
Rutland Regional Medical Center

S

Springfield Community Health Team
Southwestern Vermont Medical Center
Southwestern Vermont Council on Aging
Support and Services at Home

T

Thomas Chittenden Health Center

U

University of Vermont
Home Health & Hospice
Larner College of Medicine
Medical Center
Porter Medical Center
U.S. Committee for Refugees and Immigrants Vermont

V

Vermont Blueprint for Health
Vermont Department of Health
Healthy Aging
Local Health
Oral Health
Vermont Chronic Care Initiative
You First
Vermont Health Care Association
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Vermont Program for Quality in Health Care
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