

2024 Toolkit and Resource Guide

**Diabetes Self-
Management Education
and Support (DSMES)
Services and National
Diabetes Prevention
Programs (National
DPP) and the
Community Pharmacy**

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Adapted from CRMC's 2023 Toolkit and Resource Guide,
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INTRODUCTION TO DSMES



Overall Burden of Diabetes^{1,2,15}

- Health, social, and economic burden in the United States
 - 8th leading cause of death
 - 38.4 million Americans have diabetes
 - (22.8% of adults who have diabetes are undiagnosed)
 - 1.2 million American are diagnosed with diabetes each year
 - As of 2022, diabetes costs the United States \$413 billion annually
 - Individuals with diabetes are at an increased risk for major health complications including, but not limited to a variety of micro- and macrovascular related conditions such as nervous system damage, renal disease, cardiovascular conditions, osteoporosis, blindness, Alzheimer's Disease and dementia

DSMES: Proven Benefits^{1,2}

- Diabetes Self-Management Education and Support (DSMES): an evidence-based cost-effective tool and service proven to help improve health behaviors and outcomes, while preventing or delaying the progression of diabetes-related complications, encouraging long-term lifestyle behavior change (i.e. physical activity, nutrition/eating patterns), increasing quality of life, and decreasing diabetes-related depression through healthy coping skills
 - Provides diabetes patients with the knowledge, skills, and confidence to accept responsibility for their self-management and sustain self-management behaviors and strategies that are implemented through DSMES interventions
- Reduces hospital admissions and readmissions, as well as lifetime healthcare costs, due to the decreased risk in diabetes-related complications
- Type 2 diabetes patients who received DSMES achieved statistically significant decreases in hemoglobin A1C (average decrease of 0.57 to 1%), compared to those who did not receive DSMES
- Improvements in lipid profiles, weight, and blood pressure are also noted

- Implementing DSMES services in a community pharmacy setting is ideal as patients with diabetes see a pharmacist 7 times more than they see a primary care physician
- On average, patients with diabetes visit their treating provider 2 to 4 times per year (average appointment lasting 15 to 20 minutes); thus patients spend < 1% of their life with their healthcare professionals
 - Emphasizes the importance of decreasing gaps in availability and increasing access to DSMES services

ADA Recognition and ADCES Accreditation²¹

- The American Diabetes Association (ADA) and the Association of Diabetes Care and Education Specialists (ADCES) are two organizations dedicated to preventing and curing diabetes and improving the lives of those affected by diabetes. Both organizations are authorized by the Centers for Medicare and Medicaid Services to accredit entities that offer DSMT for Medicare beneficiaries.
- ADCES accreditation or ADA recognition is required be able to bill for services offered to Medicare beneficiaries with diabetes.

ADCES DSMES Accreditation and ADA DSMES Recognition²¹

| ADCES DSMES Accreditation and ADA DSMES Recognition | | |
|---|--|---|
| | ADCES | ADA |
| Program Title | Diabetes Education Accreditation Program (DEAP) | Education Recognition Program (ERP) |
| Guiding Standard | National Standards for DSMES | National Standards for DSMES |
| Cost | <ul style="list-style-type: none"> - First site: \$1,100 - Branch locations: \$100 per location - Community sites: Free - Same fee structure for renewal | <ul style="list-style-type: none"> - First side: \$1,100 - Expansion sites: Free (can add unlimited sites) - Multi-sites: \$100 per site (can add unlimited sites) - Same fee structure for renewal |
| Initial Application Process | <ul style="list-style-type: none"> - Complete online application - Upload supporting documentation - Complete a telephone interview | <ul style="list-style-type: none"> - Contact ADA to be set up in the application portal - Complete the online new service application - Submit supporting documentation |
| Renewal Application | <ul style="list-style-type: none"> - Submit an online re-accreditation application - Pay the re-accreditation fee - Upload supporting documentation | <ul style="list-style-type: none"> - Complete the renewal application - Pay the renewal fee - Submit supporting documentation |
| Renewal Time Period | Every 4 years | Every 4 years |
| Accreditation and recognition processes are designed to ensure that DSMES providers offer high-quality care to participants and are aligned with population health goals | | |

Disparities in DSMES Availability^{1,2}

- ADA-recognized or ADCES-accredited DSMES programs are offered in 56% of counties across the United States, yet 62% of rural counties do not have a DSMES service in place
- In the U.S., < 5% of Medicare beneficiaries with diabetes and < 6.8% of privately insured individuals with diabetes have participated in DSMES services

¹ [Site Index | Diabetes Self-Management Education and Support \(DSMES\) Toolkit | CDC](#)

² [2022 National Standards for Diabetes Self-Management Education and Support | Diabetes Care | American Diabetes Association \(diabetesjournals.org\)](#)

²¹ [DSMES Pharmacy Billing Playbook \(cdc.gov\)](#)

Process Map: Step-by-Step Approach

Implementing DSMES Services in a Community Pharmacy Setting

DSMES service is implemented in community pharmacy setting, aligned with 2022 National Standards for DSMES



DSMES Team must track & report outcomes (changes in A1C, weight, blood pressure); importance of data collection must be continually emphasized



Pharmacy markets the service to patients & providers within the community, being mindful of relevant barriers



Treating provider (physician, NP, PA) submits referral referring eligible patients to local pharmacy offering the service



Once 1 – 6 months of initial cycle of service is complete, apply for ADA Education Recognition or ADCES Accreditation



Application review process takes up to 30 days; Quality Coordinator will be notified via email regarding approval or need for additional documents



Pharmacy can begin billing for the provided service once application is approved



ERP Annual Status Report must be completed during anniversary month of ADA recognition; ADA ERP recognition renewal required every 4 years

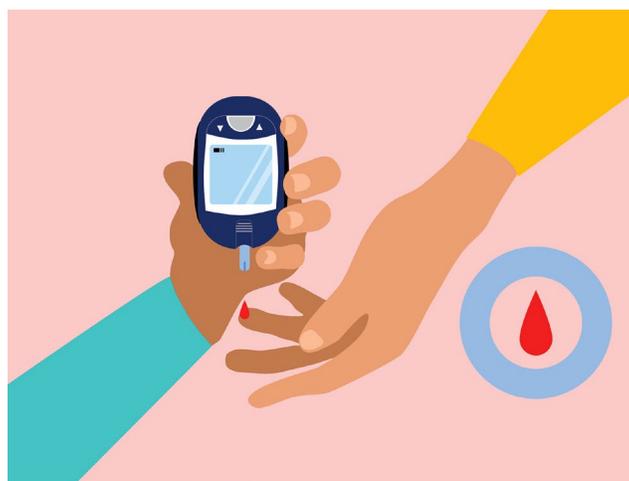


Maintain service sustainability/continue marketing services



Evaluate data collected thus far; consider publication

2022 NATIONAL STANDARDS FOR DSMES



Summary of 2022 National Standards for DSMES

Standard 1: Support for DSMES Services²

- ✓ Team will seek leadership support from sponsor organization (will provide guidance & support for services to facilitate alignment with organizational resources & the needs of the community being served)

Standard 2: Population & Service Assessment²

- ✓ Chosen target population should be evaluated to determine, develop, & enhance the resources, design, & delivery methods that align with the target populations' needs & preferences

Standard 3: DSMES Team²

- ✓ Will implement collaborative DSMES services: ≥1 quality coordinator (oversees effective implementation, evaluation, tracking, & reporting of outcomes), ≥1 RD or RDN, or pharmacist, or BC-ADM or CDCES; Diabetes Care Coordinators (DCCCs) can include CHWs
 - Specific CE requirements

Standard 4: Delivery & Design of DSMES Services²

- ✓ A curriculum will be utilized to guide evidence-based content; team will have knowledge of emerging evidence, advances in education strategies, pharmacotherapeutics, local/online peer support, psychosocial resources, & delivery strategies relevant to the population they serve

Standard 5: Person-Centered DSMES²

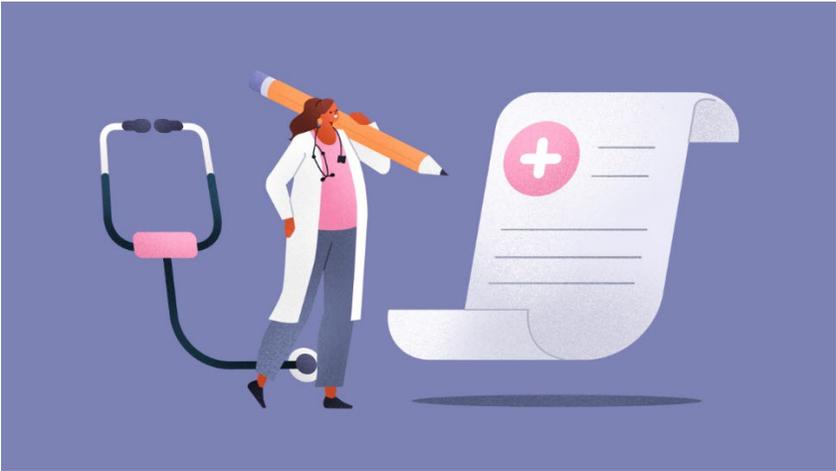
- ✓ Each person's DSMES will be unique and based on the person's concerns, needs, & priorities collaboratively determined as part of a DSMES assessment
- ✓ The team will monitor & communicate the service outcomes to the referring qualified healthcare professional

Standard 6: Measuring & Demonstrating Outcomes of DSMES Services²

- ✓ Ongoing CQI strategies will be in place to measure the impact of the services
- ✓ Systematic evaluation of the process & outcomes data will be conducted to identify areas for improvement & to guide services optimization and/or redesign

²Refer to Appendix (The 2022 National Standards for DSMES) for a complete list of criteria for each standard. The National Standards are the basis for recognition by the American Diabetes Association (ADA) & accreditation by the Association of Diabetes Care and Education Specialist (ADCES); the Standards also serve as a guide for the DSMES & insurance providers to ensure patients with diabetes receive DSMES services that are evidence based and up to date.

REIMBURSEMENT & REFERRAL REQUIREMENTS



DSMES Billing^{1,3,4,5,16,20}

Although pharmacists may not directly bill The Centers for Medicare and Medicaid Services (CMS) for the provision of diabetes self-management training (DSMT), a pharmacy that is a Medicare Part B provider may bill CMS for these services.

- DSMT services must have achieved recognition by the **American Diabetes Association (ADA)** or accreditation from the **Association of Diabetes Care & Education Specialists (ADCES)**
- The DSMT provider (the pharmacy) is considered the sponsoring organization
 - Must obtain a National Provider Identifier (NPI) number
 - If the sponsoring organization is new to Medicare, CMS Form 855B must be submitted to the regional Medicare Administrative Contractors (MAC); a copy of the certificate of ADA recognition or ADCES accreditation must be submitted to the local MAC
 - The sponsoring organization must enroll as a Medicare Part B provider (even if they are already enrolled as Medicare suppliers) to bill for the DSMT benefit
- Medicare Part B covers initial and follow-up outpatient DSMT
 - Initial DSMT
 - A e-referral or write referral form is required from the beneficiary's treating diabetes provider (physician, or qualified non-physician practitioner – i.e. nurse practitioner, physician assistant, clinical nurse specialist; must be an active Medicare provider or in opt out status); refer to ADA website for “ADA Sample Referral Form” & “ADA Short Sample Referral Form;” form must indicate:
 - Date
 - Beneficiary's name
 - Diagnosis or ICD-10 diagnosis code
 - Need for DSMT
 - If DSMT is to be group or individual
 - If all hours are indicated to be individual, ≥ 1 of the 3 conditions allowing for individual DSMT must be mentioned
 - Quantity of initial DSMT hours to be furnished (≤ 10 hours)
 - The topics to be taught

- Referring provider's signature (not stamped, but e-signature in the EHR is acceptable) and NPI number
- Confirm beneficiary has not received any initial DSMT in the past; inform beneficiary that 10 hours of initial DSMT must be completed within 12 consecutive months starting with the first date of service to allow for billing for Medicare payment
 - If the beneficiary has already received initial DSMT paid by another health insurance company, beneficiary is still eligible to receive Medicare benefit of 10 hours of initial DSMT
 - To check if beneficiary has received initial DSMT through Medicare in the past:
 - <https://www.cms.gov/files/document/mln8816413-checking-medicare-eligibility.pdf>
- 1 hour of individual DSMT is payable during the initial provision of DSMT; however, the remaining 9 hours must be furnished as group services unless 1 of 3 conditions are fulfilled:
 - No DSMT group class is available for ≥ 2 months from the referral date
 - The referring provider indicates on the referral that the beneficiary has ≥ 1 barrier to group learning (i.e. non-ambulatory, reduced vision, hearing and/or cognition; language barrier)
 - The referring provider indicates on the referral that the beneficiary needs additional insulin training
- DSMT Follow-up
 - Meeting a particular condition for furnishing individual follow-up is not required; referral form must be submitted indicating:
 - Date
 - Beneficiary's name
 - Diagnosis or ICD-10 diagnosis code
 - Need for DSMT
 - Referring provider's signature (not stamped, but e-signature in the EHR is acceptable) and NPI number

- Following the initial DSMT intervention, 2 hours are allowed for DSMT follow-up
 - 2 hours of follow-up annually can be furnished on a calendar year basis
 - There are specific Medicare time frames for follow-up DSMT
- The ADA, ADCES, and the Academy of Nutrition and Dietetics developed the “DSMES Algorithm Action Steps,” an evidence-based approach that indicates 4 instances when referral to DSMES services is crucial (see Appendix)
 - At diagnosis
 - During annual assessment
 - When a person with diabetes has new complicating factors
 - Upon transitions in care
- Confirm that DSMT billing procedure codes are entered into the billing system’s charge master; procedure codes required by Medicare for the DSMT claim are G0108 and G0109
 - 10 initial DSMT hours and 2 hours of DSMT follow-up are to be furnished in increments of ≥ 30 minutes, face to face
 - G0108 – DSMT, individual, per 30 minutes
 - G0109 – DSMT, group (≥ 2), per 30 minutes
 - Only 3 hours of G0108 and 6 hours of G0109 can be billed on the same day/same patient
 - Billing Rates:
 - G0108 – Individual DSMES (per 30 minutes): \$59.56
 - G0109 – Group DSMES (2 or more) (per 30 minutes): \$17.25
 - 97802 – Individual Initial MNT (per 15 minutes): \$40.47
 - 97803 – Individual Follow Up MNT (per 15 minutes): \$35.31
 - State-specific fee schedules can be found on the CMS website: <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>
- DSMT Telehealth Services
 - Recognized and/or accredited pharmacies can provide **Telehealth** DSMT services that can be billed for DSMT telehealth services regardless of the provider type furnishing the service

- Per CMS, providers must report the POS code that would have been reported had the services been provided in person (i.e. POS 11 modifier, not POS 02 modifier) as well as the 95 modifier
 - Medicare pays the same amount for telehealth services as it would if the service were furnished in person
 - Telehealth options include videoconferencing, telephone, and texting
- Medi-Cal
 - Please refer to [MTM-Services \(ca.gov\)](#) for services covered by DHCS Medi-Cal MTM program.
 - DHCS Medi-Cal MTM Application: [DHCS-6502-MTM-Application.pdf](#)
 - Medi-Cal MTM Program manual and requirements for billing, documentation: [mtmserv.pdf \(ca.gov\)](#)

Marketing & Sustainability of DSMES Services^{1,3,4,5,22}

- It is very important to establish a referral network.
 - Helps facilitate the establishment and growth of the program
 - Leads to consistent patient referrals and patient graduations
 - Encourages the patient to further be a champion of their health
- Creating and updating promotional materials (i.e. website, handouts, quarterly newsletters, social media accounts, brochures, flyers)
 - See Appendix for sample flyer
 - Serve as routes of educating and empowering providers and patients with diabetes regarding availability and benefits of DSMES services; may encourage patients to seek referrals from their providers

¹[Site Index | Diabetes Self-Management Education and Support \(DSMES\) Toolkit | CDC](#)

³[DSMT services may continue to be provided via telehealth \(adces.org\)](#)

⁴[Diabetes Education-DSMES \(adces.org\)](#)

⁵[Referral Process | Diabetes Self-Management Education and Support \(DSMES\) Toolkit | CDC](#)

⁶[Education Recognition Program | American Diabetes Association](#)

¹⁶[DSMES Post COVID-19 Updated 5/11/23 | American Diabetes Association](#)

²⁰[Patient Success With DSMES Through Telehealth | Diabetes Self-Management Education and Support \(DSMES\) Toolkit | CDC](#)

²²[Establishing a Referral Network | Diabetes Self-Management Education and Support \(DSMES\) Toolkit | CDC](#)

WHAT ABOUT BARRIERS?



Potential Barriers^{7,8,17}

- Programmatic barriers to initiating or sustaining DSMES services
 - Limited providers and support from providers in the areas of the service
 - Low reimbursement rates
 - Sustaining sufficient volume of participants, such as in rural populations
 - Administrative challenges in regards to remaining in compliance with ADA recognition standards as well as marketing the service
- Provider-level barriers to referral
 - Providers may not be aware of the importance of DSMES, availability locally, and the referral process
 - Provider may be concerned of out-of-pocket costs
 - Lack of relationship between the provider and pharmacies offering the service
- Tips for engaging providers:
 - Refer to Appendix for ADCES Sample Provider Letter
 - Explain the benefits of the service, such as the fact that providers can focus more on the clinical management of the patient's condition while educators within the DSMES service can focus on the education
 - EHR capabilities can help providers identify their patients with diabetes, who may benefit from the service, and increase referrals based on high A1Cs
 - Establish relationship with providers: Providers can be a treating physician, physician assistant, nurse practitioner, or advanced NP
 - Specialty providers may not make direct referrals, but can increase interest in DSMES services
 - Area Agencies on Aging (AAAs) can provide referral assistance
 - Community outreach can help promote DSMES programs
 - Marketing materials are available online for public distribution ([DSMES Promotion Playbook Resources | Diabetes Self-Management Education and Support \(DSMES\) Toolkit | CDC](#)), such as the one below:

Learn ways to manage diabetes that fit YOUR life.

Did you know? Personalized services to manage your diabetes can help you:

- ✓ Set and track your health goals.
- ✓ Learn how to use knowledge, skills, and tools to manage your diabetes.
- ✓ Practice how to fit diabetes care into all parts of your life.
- ✓ Find ways to get support when you need it.

Personalized services is here to help you whether you are newly diagnosed or have had diabetes for years.

Ask a health care provider to refer you to diabetes self-management education and support (DSMES) services or contact a program in your area to learn more.

DSMES SERVICES IN YOUR COMMUNITY
Insert program contact information here

Call or visit us today!

CDC U.S. Department of Health and Human Services

- Individual barriers to access and participation
 - May not be aware of the availability and benefits of the services
 - Financial resources in relation to purchasing healthy food options
 - May not have access, such as in rural areas
 - Classes that are not offered on weekends or evenings may be inconvenient
 - May not be willing to participate in group classes
 - Insurance, transportation, childcare issues
 - Lack of family support or language and literacy-related needs
 - Access to safe places to exercise

- Tips for overcoming mentioned barriers:
 - Local health department can offer free cooking or exercise classes
 - Work with language interpreters and/or integrate bilingual educators in the team, offer educational materials in preferred language
 - Teach patients about affordable healthy food options
 - Use plain language and visual to help participants comprehend content, such as showing the amount of sugar in 1 soda
 - Avoid recommending that the participant eliminate foods that are central to his/her culture

- **Search tools to locate local DSMES services:**
 - https://professional.diabetes.org/erp_list_zip
 - <http://publichealth.lacounty.gov/diabetes/management/dsmesprogram.htm>
 - 1-800-DIABETES (800-342-2383)

Underserved Communities^{7,8}

- Prevalence of diagnosed diabetes in the U.S.
 - American Indian/Alaska Native: 15.1%
 - Non-Hispanic Black: 12.7%
 - Hispanic ethnicity: 12.1%
 - Asian: 8%
 - Non-Hispanic White: 7.4%
 - Adults with less than a high school education: 12.6%
 - Adults with a high school education: 9.5%
 - Adults with more than a high school education: 7.2%
 - Those with low socioeconomic status are affected at disproportionately increased rate

- Ethnic and racial minorities are at an increased risk of developing diabetes related complications (retinopathy, end-stage renal disease, depression)
 - Patients with diabetes and comorbid depression have less adherence to self-management behaviors than those without depression
 - Non-Hispanic Black and Hispanic Americans have A1C values that are 0.6% higher than non-Hispanic Whites
- Refer to Appendix for:
 - ADA DSMES Support Plan
 - Compilation of local resources on emotional health, nutrition, physical activity, smoking cessation, support groups, etc.
 - ADCES Sample Provider Letter
 - CDC Intervention Tailoring Worksheet

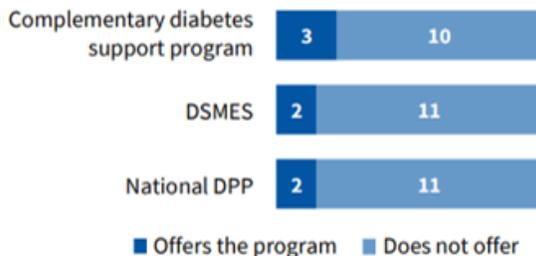
DSMES Survey Results From LA County Pharmacies

In collaboration with the Los Angeles County Department of Public Health, the California Right Meds Collaborative disseminated a survey to pharmacies in LA to gauge experience with and interest in implementing DSMES services in their pharmacies. An excerpt of the results is below:

Key Findings

- **Pharmacy characteristics:** Most pharmacies (61.5%, or 8/13) reported that more than half of the patients at their pharmacy site were 65 years or older and have multiple chronic conditions.
- **Pharmacy interest in diabetes programming:** Nearly half of pharmacies (46.2%, or 6/13) reported being interested and ready to offer either DSMES or the National DPP.

Few pharmacies currently **offer any diabetes programming.**



- **Facilitators and barriers to implementing DSMES:**

Among pharmacies interested in offering DSMES, half (50.0%, or 3/6) reported leadership buy-in and sufficient staffing as potential facilitators. Most (83.3%, or 5/6) reported billing and/or reimbursement and a low return on investment as potential challenges.

- **Facilitators and barriers to implementing the National DPP:**

Among pharmacies interested in offering the National DPP, half (50.0%, or 3/6) reported leadership buy-in and sufficient staffing as potential facilitators. All (100%, or 6/6) reported billing and/or reimbursement as the key challenge.

- **Need for technical assistance (TA), resources, and trainings on diabetes programming:**

Almost all pharmacies would like TA, resources, and/or trainings on billing and/or reimbursement for DSMES (84.6%, or 11/13) or the National DPP (92.3%, or 12/13).

- **Assessing and addressing social needs among patients:**

Most pharmacies (61.5%, or 8/13) do not currently assess for social needs among their patient population.

Case Study: Experience of 3 LA County Pharmacies Providing DSMES

In 2024, the California Right Meds Collaborative, an initiative of University of Southern California Mann School of Pharmacy, met with three LA county community pharmacies who have had experience providing DSMES services in the past. The experiences of these pharmacies ranged in terms of when they provided the services – some are actively providing services, while others provided services years ago, but stopped due to programmatic setbacks. Major challenges included:

- Attaining physician buy-in for the program to receive patient referrals
- Cost of implementation
- Billing
- Time commitment the program required

Since some of the pharmacies provided DSMES services 5+ years ago, many systematic updates to the program have been made. Two major updates in implementation that have been recently enacted are: (1) The potential for community health workers (CHW) involvement, and (2) The use of telehealth communication to ease some of the burden of in-person sessions/coordination. These updates are tremendously helpful, since CHWs are very effective at engaging the local community and telehealth allows for greater flexibility for patients interested in DSMES. As updates and policy changes continue to refine implementation of DSMES and National DPP services in pharmacies, an optimal model of implementation is constantly evolving.

⁷[How to Increase Referrals and Overcome Barriers to Participation | Diabetes Self-Management Education and Support \(DSMES\) Toolkit | CDC](#)

⁸[Establishing a Referral Network | Diabetes Self-Management Education and Support \(DSMES\) Toolkit | CDC](#)

¹⁷[DSMES Promotion Playbook Resources | Diabetes Self-Management Education and Support \(DSMES\) Toolkit | CDC](#)

CDC'S NATIONAL DIABETES PREVENTION PROGRAM

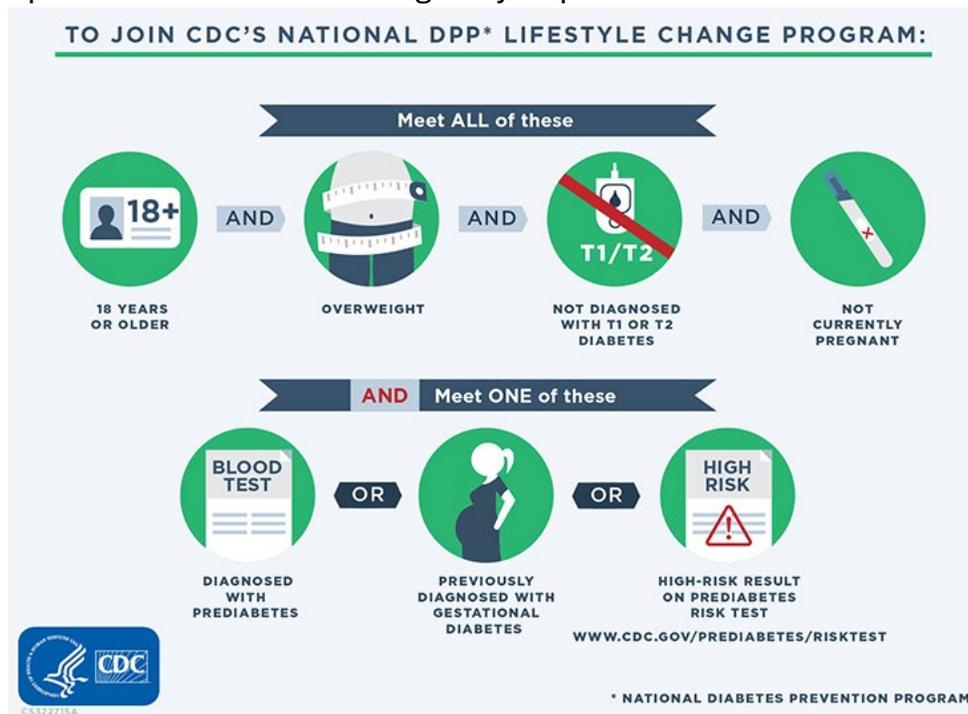


Increasing Burden of Prediabetes^{9,10,11,12,13,14}

- In addition to the overall burden of diabetes (see “Introduction to DSMES”), there is an increasing burden of prediabetes in the U.S.
 - 96 million adults in the U.S. have prediabetes

What is National DPP?

- Year-long program, 22 total sessions (16 weekly sessions during the first 6 months and 6 monthly sessions during the second 6 months)
- This graphic below outlines the eligibility requirements for National DPP:



National DPP: Proven Benefits^{9,10,11,12,13,14}

- The National DPP was created in 2010 to address this burden; a CDC-recognized evidence-based lifestyle change program designed to prevent or delay the onset of type 2 diabetes in those at risk
 - Focuses on healthy eating, physical activity, development of coping skills
- Participants who lost 5-7% of their body weight and added 150 minutes of exercise per week, reduced their risk of developing type 2 diabetes by 58% (71% for people over 60 years old) over 3 years

- Participants who attended 12 of 24 sessions, lost an average of 4.2 lbs. over a ~17 weeks, increased HDL levels by 1.75 mg/dl
- 50% of weight loss persisted after 5 years
- Participants who participate in National DPP decrease their 10-year risk of developing type 2 diabetes by 33%
- Results from large National DPP clinical studies have proven similar results as mentioned
 - Da Qing Diabetes Prevention Study
 - Finnish Diabetes Prevention Study (DPS)
 - U.S. Diabetes Prevention Program Outcomes Study (DPPOS)
- National DPP interventions have demonstrated cost-effectiveness; can be embedded within value-based care and payment models, covered by Medicare (“Medicare DPP”)

Medicare Diabetes Prevention Program (MDPP)^{25,26,27}

- The Medicare Diabetes Prevention Program (MDPP) aims to prevent type 2 diabetes in high risk individuals who are Medicare patients
 - Organizations can become MDPP suppliers, that furnish healthcare services under Medicare

Medicare Diabetes Prevention Program (MDPP)

Opportunity for Eligible Organizations to Get Involved

What is the Medicare Diabetes Prevention Program?

The Medicare Diabetes Prevention Program (MDPP) is a lifestyle change program that aims to prevent the onset of type 2 diabetes among Medicare patients at high risk of developing diabetes. MDPP provides practical training in long-term dietary change, increased physical activity, and behavior change strategies for weight loss. The 2012-2015 DPP model test showed that **participation in the program reduced per-person spending and improved participant health.**¹

What are the benefits?

Payment, savings, quality, and community impact

-  **Receive payments** for furnishing 22 MDPP sessions over 12 months and for helping participants achieve and maintain weight loss.
 - National Association of Chronic Disease Directors (NACDD) developed the [MDPP Revenue Projection Tool](#) to help suppliers understand their potential participant pool and revenue in a specific geographic area.
-  **Help reduce health care costs in your community** through value-based care, weight loss, and improved population health.
 - DPP can decrease the risk of type 2 diabetes in individuals with prediabetes by 58%, and by 71% among those aged 60 and older.²
-  **Advance health equity priorities** by reaching underserved or high-need populations in your community.
 - To increase flexibility for participants, suppliers may offer MDPP services in person, via distance learning, or a combination of both (hybrid).
-  **Empower individuals with increased risk** to take action to improve their health by giving them the tools they need to make lifestyle changes.
 - Support individuals with prediabetes to form new habits that promote healthier eating, stress reduction, and increased physical activity.

Become an MDPP Supplier

-  **Recruit and Train MDPP Coaches**
Scholarships are available to help train coaches that serve underserved or high-need populations. See the [CDC National DPP Customer Service Center](#) for more information.
-  **Achieve CDC Recognition**
Some organizations can be fast-tracked to preliminary CDC recognition, allowing them to apply to enroll as MDPP suppliers. See the [CDC National DPP Customer Service Center](#) for more information.
-  **Enroll as an MDPP supplier**
Apply online via [PECOS](#) or via the [CMS-20134](#) paper application. PECOS is recommended for faster processing. See the [Enrollment Preparation Guide](#) for more information.

Partner with an MDPP Supplier

-  **Join a CDC Umbrella Hub Arrangement (UHA)**
Organizations that want to deliver MDPP but don't have the administrative capacity should consider partnerships which allow organizations to share CDC recognition status, manage referrals, and streamline billing. See the CDC [UHA](#) for one potential option.
-  **Promote awareness of MDPP**
Refer patients, friends, or family with a high risk of developing type 2 diabetes to join MDPP. Find MDPP suppliers in your area using the [MDPP supplier map](#).

- The following steps to become a supplier are outlined below and available in full detail here: [PowerPoint Presentation \(cms.gov\)](#) and [Salesforce](#) (this latter link also provides detailed information about MDPP billing on page 14)
 1. Obtain or Verify NPI and Taxonomy Code
 2. Confirm MDPP Supplier Eligibility
 3. Enroll as an MDPP Supplier and Obtain the Correct PTAN

Diabetes Prevention Recognition Program (DPRP) Process^{9,10,11,12,13,14,23}

- DPRP main objectives are to ensure program quality by recognized organizations or providers and to give standardized operating procedures for providers.
- Pharmacists and members of the pharmacy workforce (including technicians, students, and community health workers) are able to participate in a National DPP program as they are in contact and accessible to people at high risk of developing type 2 diabetes. Through a National DPP program, pharmacy staff could help patients by:
 - Raising awareness of prediabetes and the National DPP
 - Screen and test for prediabetes, as well as garnering interest and enrolling patients into a National DPP program
 - Delivery of the National DPP lifestyle change program.
- Pharmacies can apply for CDC recognition for free
- Preliminary or full recognition is required for reimbursement through most insurances (including Medi-Cal and Medi-Cal MCPs)
- Quality assurance: CDC recognizes National DPP programs that meet certain standards
 - An approved curriculum (CDC has developed its own evidence-based curriculum offered for free) must be in place, led by a trained lifestyle coach (i.e. pharmacy staff members: pharmacists, pharmacy residents, pharmacy technicians; pharmacy students can support the coach); team members must also include a program coordinator (i.e. pharmacists)
 - CDC's PreventT2 National Diabetes Prevention Program curriculum, Spanish version available
 - For a full overview of the 2024 DPRP standards, please reference the following link: [2024 DPRP Standards and Operating Procedures \(cdc.gov\)](#)
- Data demonstrating programs' positive impact should be submitted every 6 months (participant attendance, physical activity minutes, and changes in weight)

CDC’s Diabetes Prevention Impact Toolkit^{9,10,11,12,13,14}

- Online tool to help employers, insurers, and/or state health departments calculate estimates of:
 - Total cost of delivering a National DPP
 - Total health benefit resulting from the program
 - LY gained and QALY saved
 - Cost-effectiveness of the program
 - ROI
 - Information above is calculated based on values that the user submits in relation to the target population
 - <https://nccd.cdc.gov/Toolkit/DiabetesImpact>

Billing^{9,10,11,12,13,14,24}

- Medicare: Updated CMS Rates for Calendar Year 2024 are listed below:

Table 1. CY 2024 MDPP Payment Schedule

| HCPCS G-Code | Payment Description* | CY 2024 |
|------------------------------|--|--------------|
| G9886* | Behavioral counseling for diabetes prevention, in-person, group, 60 minutes | \$25 |
| G9887* | Behavioral counseling for diabetes prevention, distance learning, 60 minutes | \$25 |
| G9880 | 5 percent weight loss achieved from baseline weight | \$145 |
| G9881 | 9 percent weight loss achieved from baseline weight | \$25 |
| G9888** | Maintenance 5 percent weight loss from baseline in months 7-12 | \$8 |
| G9890*** | Bridge payment | \$25 |
| Total Maximum Payment | | \$768 |

**Medicare pays up to 22 sessions billed with codes G9886 and G9887, combined, in a 12-month period:*

Months 1-6: 1 in-person or distance learning session every week (max 16 sessions)

Months 7-12: 1 in-person or distance learning session every month (max 6 sessions)

*** MDPP suppliers must submit claim for 5 percent weight loss (G9880) prior to submitting claims for the maintenance 5 percent Weight Loss from baseline in months 7-12 (G9888).*

****Note that the bridge payment does not count towards the 22 MDPP sessions payable in CY 2024.*

- For claims billed in Calendar Year 2023 please refer to previous HCPCS G-Code for appropriate claims processing. Programs have 12 months from the Date of Service to submit a claim to their MACs.
- DHCS Medi-Cal billing for National DPP Services:
 - Pharmacies are eligible to apply to enroll as a Fee-For-Service Medi-Cal to provide National DPP services.
 - Please see the following document for standards and criteria:
 - [DPP-Requirements-For-Enrollment.pdf \(ca.gov\)](#)

- California State Medi-Cal coverage reimbursement, coding, and billing can be found [California’s State Story of Medicaid Coverage - National DPP Coverage Toolkit](#) and is outlined below:

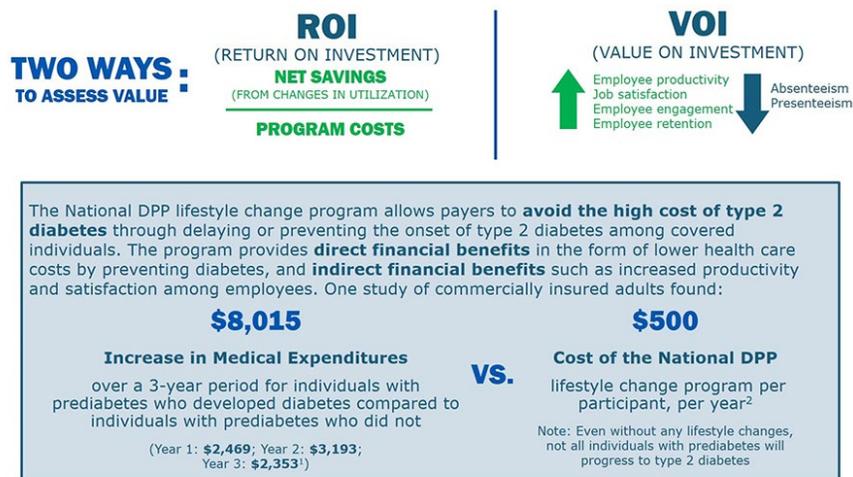
Reimbursement, Coding, and Billing

Medi-Cal’s HCPCS codes are intended to track a National DPP lifestyle change program participant’s progress. These codes provide useful data to providers, program members, and state agencies. Medi-Cal reimburses in both the FFS and the managed care delivery systems as described below. For a Medi-Cal eligible participant in the National DPP lifestyle change program that attends all the sessions for the two-year program and attains all the weight loss goals, the CDC-recognized organization would receive a total reimbursement of **\$536**.

CDC-recognized organizations planning to bill Medi-Cal for reimbursement can find the required process for enrollment and reimbursement outlined in the [Guide for Diabetes Prevention Providers New to Medi-Cal](#).

- Core Sessions Months 1-6:
 - (G9873) 1st session attended – **\$20**
 - (G9874) 4 sessions attended – **\$40**
 - (G9875) 9 sessions attended – **\$72**
- Core Maintenance with 5% weight loss:
 - (G9878) 2 sessions attended in months 7-9 – **\$48**
 - (G9879) 2 sessions attended in months 10-12 – **\$48**
- Core Maintenance without 5% weight loss:
 - (G9876) 2 sessions attended in months 7-9 – **\$12**
 - (G9877) 2 sessions attended in months 10-12 – **\$12**
- Ongoing Maintenance Months 13-24 (maintained 5% weight loss and attended 2 sessions every 3 months):
 - (G9882) Months 13-15 – **\$40**
 - (G9883) Months 16-18 – **\$40**
 - (G9884) Months 19-21 – **\$40**
 - (G9885) Months 22-24 – **\$40**
- Weight Loss Performance:
 - (G9880) achieved 5% weight loss OR had absolute reduction of waist circumference by 3.2 cm during months 1-12 – **\$128**
 - (G9881) achieved 9% weight loss during months 1-24 – **\$20**
- Bridge Payment transitioning from a different DPP provider:
 - (G9890) Months 1-24 for first DPP core session, core maintenance session, or ongoing maintenance session – **\$20**

- Direct delivery cost of administering the program to a participant who completes the program in its entirety: **\$500 per participant**
 - Possibly an additional \$500 per participant (i.e. addressing social determinants of health and removal of barriers to participation)



SOURCES: 1. Kahn, T., Tsipras, S., Wozniak, G., *Medical Care Expenditures for Individuals with Prediabetes*. Population Health Management, 2017. | 2. CDC, *How Type 2 Diabetes Affects Your Workforce*. 2018.

- Can be offered via telehealth
 - Participants have been seen to experience equal or greater weight loss when participating via telehealth National DPP is opposed to in-person sessions
- Local National DPP search:
 - <http://publichealth.lacounty.gov/phcommon/public/nationaldpp.cfm>

- ⁹[Nutrition Therapy for Adults With Diabetes or Prediabetes: A Consensus Report | Diabetes Care | American Diabetes Association \(diabetesjournals.org\)](#)
- ¹⁰[National Diabetes Prevention Program | National Diabetes Prevention Program | CDC](#)
- ¹¹[Diabetes Prevention Impact Toolkit - Diabetes Toolkit \(cdc.gov\)](#)
- ¹²[UPDATE: DSMT service may continue to be provided via telehealth \(adces.org\)](#)
- ¹³[Ad Lucem_Final Report.pdf \(lacounty.gov\)](#)
- ¹⁴[The National Diabetes Prevention Program: About the National DPP - National DPP Coverage Toolkit](#)
- ²³[Pharmacist Toolkit: Participate in the National Diabetes Prevention Program | National Diabetes Prevention Program | CDC](#)
- ²⁴[California's State Story of Medicaid Coverage - National DPP Coverage Toolkit](#)
- ²⁵[PowerPoint Presentation \(cms.gov\)](#)
- ²⁶[PowerPoint Presentation \(cms.gov\)](#)
- ²⁷[Salesforce](#)

USE OF COMMUNITY HEALTH WORKERS (CHW)

The Many Roles of Community Health Workers



Direct Service | Coordinating Care | Building Capacity | Coaching | Health Education
Cultural Mediation | Advocacy | Outreach | Evaluation & Research | Assessments

DSMES/National DPP and Community Health Workers (CHWs)

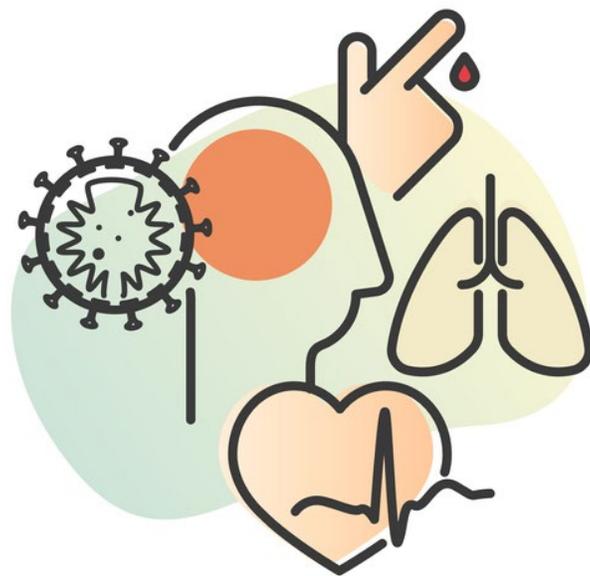
CHWs proved to be vital during the peak of the COVID-19 pandemic, engaging and motivating patients to seek vaccinations and providing other supportive care services. The value of CHWs in improving uptake and outcomes from preventative health services, as well as narrowing health disparities, has been shared in many studies (<https://nachw.org/>). California DHCS is budgeting over \$200 million annually for CHW services provided to Medi-Cal patients. The range of services include health screenings, promoting healthy lifestyles, preventative health services, healthcare navigation / care coordination, health education, and identifying and connecting patients to resources for social needs. Pharmacy technicians already provide these services in many pharmacies (although not reimbursed), and are often members of the local community that are culturally and linguistically aligned with the population served.

As a result, certifying pharmacy technicians as CHWs is a natural alignment for addressing essential health needs that can be billed directly to DHCS or participating Medi-Cal managed care plans. This includes support for DSMES services such as assisting with diabetes education and guidance, recruiting and retaining patients in the program, and utilizing patient engagement techniques such as motivational interviewing and shared decision-making to help build and improve a patient self-management skills.

In order for pharmacies to bill for providing CHW services to Medi-Cal patients, CHW certification for individual providers is required. The USC Mann School of Pharmacy offers a practical 3-part [CHW certification course](#), at the lowest registration fee in the industry, with a focus on community pharmacies and health systems. The course meets state and national standards for CHW certification and is open to anyone; participants have included pharmacy technicians and pharmacists from pharmacies, health plans, and health systems.

Certifying pharmacy technicians as CHWs is potentially high-value strategy for improving the efficiency and effectiveness of DSMES service delivery, as well as addressing gaps in vital health and social needs.

COMORBID CONDITIONS



Prevalence of Cardiovascular Disease (CVD) in the U.S.¹⁸

- Leading cause of death for men, women, and those of most racial and ethnic groups
- 1 person dies every 34 seconds from CVD
- In 2020, ~697,000 CVD-related deaths
- Coronary Artery Disease (CAD) is the most common type of CVD
 - In 2020, led to 382,820 deaths in the U.S.
 - ~20 million adults have CAD
- Someone has a heart attack every 40 seconds
- ~800,000 people have a heart attack annually
- 1 out of 5 heart attacks are silent
- In recent years, CVD costs the U.S. \$229 billion annually

Leading CVD risk factors¹⁸

- Diabetes
- Hypertension (leading cause of CVD and stroke, single most modifiable risk factor for ischemic stroke)
- Hyperlipidemia (specifically high LDL cholesterol)
- Smoking and secondhand smoke exposure
- Obesity
- Unhealthy diet
- Physical inactivity
- Excessive alcohol use

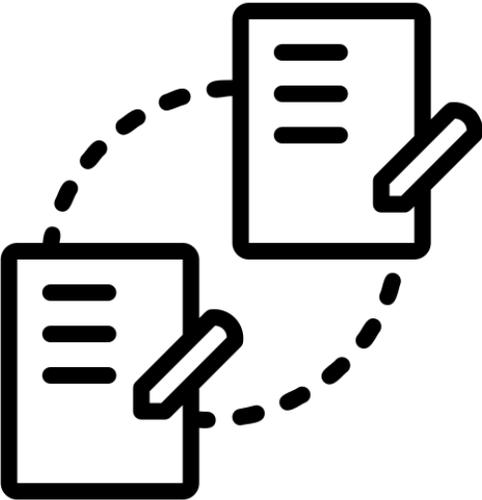
Incorporating CVD Screening within DSMES Services¹⁹

- The ASCVD Risk Estimator can be used to estimate patient's 10-year ASCVD risk
 - This tool can be useful during initial DSMES encounters as it can aid decision making relative to selection of moderate or high-intensity statin use for people with diabetes
- Hypertension
- Hyperlipidemia (POCT and/or obtaining lab values from referring provider)

¹⁸[Heart Disease Facts | Heart Disease | CDC](#)

¹⁹[ASCVD Risk Estimator + \(acc.org\)](#)

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2022 National Standards for Diabetes Self-Management Education and Support

Diabetes Care 2022;45:484–494 | <https://doi.org/10.2337/dc21-2396>

By the most recent estimates, 34.2 million people in the U.S. have diabetes (1). At the same time, 88 million people are at increased risk for developing type 2 diabetes. The U.S. also sees an increasing prevalence of both type 1 and type 2 diabetes in children and adolescents (2). Thus, more than 122 million Americans are at risk for developing devastating complications associated with chronic hyperglycemia (1). Diabetes self-management education and support (DSMES) is a critical element of care for all people with diabetes (PWD). “The purpose of DSMES is to give PWD the knowledge, skills, and confidence to accept responsibility for their self-management. This includes collaborating with their healthcare team, making informed decisions, solving problems, developing personal goals and action plans, and coping with emotions and life stresses” (3). DSMES interventions include activities that support PWD to implement and sustain the self-management behaviors and strategies to improve diabetes and related cardiometabolic conditions and quality of life on an ongoing basis. Despite progress in diabetes treatment modalities, glycemic and cardiometabolic outcomes continue to decline in the U.S. (4). Now, more than ever, the provision of DSMES is a vital component of the full treatment for diabetes.

PWD are at risk for distress, life stress, and clinical depression, which can lead to poor health outcomes (5). The National Standards for Diabetes Self-Management Education and Support (hereinafter referred to as the National Standards) encourage the DSMES team to acknowledge and address the emotional burden of living with and managing diabetes—diabetes distress—and to consider the multitude of daily demands and decisions required of PWD, their families, and caregivers (6–9). To further illustrate, PWD generally visit their primary care physician (PCP)/other qualified healthcare professional two to four times per year, where the average appointment lasts 15–20 min and addresses four or more health conditions (10). This equates to the person with diabetes (PWD) spending less than 1% of their life with their healthcare professionals (10). Therefore, diabetes management decisions largely fall on PWD and/or caregivers, further highlighting the importance of increasing access to DSMES services that support ongoing self-management and decision making.

The National Standards define timely, evidence-based, quality DSMES services that meet or exceed the Centers for Medicare & Medicaid Services quality standards. While the acronym DSMES is used in the literature and in current practice, it is important to note that the term diabetes self-management training (DSMT) is exclusively used when describing the Medicare benefit for diabetes self-management. The Medicare benefit for DSMT was established by the Balanced Budget Act (BBA) of 1997 with a final rule (65 FR 83130) published on 29 December 2000, implementing the BBA provisions and DSMT regulations (Title 42 of the Code of Federal Regulation sections 410.140 to 410.146). The DSMT benefit has reimbursement guidelines outside of the National Standards.

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The National Standards provide guidance and evidence-based, quality practice for all DSMES services, including those with no plan to seek reimbursement. The evidence supporting the 2022 National Standards clearly identifies the need to provide person-centered services that embrace cultural differences, social determinants of health (SDOH), and the ever-increasing technological engagement platforms and systems. Because the National Standards aim to promote health equity, technological advancements can often be used to achieve equitable access to DSMES (11); however, technology is not a requirement for delivery of DSMES.

Payers are invited to review the National Standards as a tool to inform and modernize DSMES reimbursement requirements and to align with the evolving needs of PWD and physicians/other qualified healthcare professionals. In the U.S., less than 5% of Medicare beneficiaries with diabetes and 6.8% of privately insured people with diagnosed diabetes have utilized DSMES services (12–14). The American Diabetes Association (ADA) and the Association of Diabetes Care & Education Specialists (ADCES) strongly advocate for health equity to ensure all PWD have access to this critical service proven to improve outcomes, both related to and beyond diabetes. Numerous studies have proven the benefits of DSMES, which include improved clinical outcomes and quality of life, while reducing hospitalizations and healthcare costs (13, 15–19). Engagement in DSMES services lowers hemoglobin A1C (A1C) by at least 0.6%, as much as many diabetes medications—however with no side effects (15). Greater A1C reductions have been associated with more than 10 h of DSMES services (15).

The 2022 National Standards update is meant to be a universal document that is easy to understand and can be implemented by the entire healthcare community. DSMES teams in collaboration with

primary care have been shown to be the most effective approach to overcome therapeutic inertia (20). While the National Standards can be implemented in any care setting, the Chronic Care Model (CCM), which replaced the Acute Care Model as a leading practice in the 1990s, focuses on proactively managing chronic diseases (21). Additionally, Minimally Disruptive Medicine (MDM) is a person-centered approach to healthcare that prioritizes the PWD's self-determined and self-chosen goals for life and health while minimizing the healthcare disruption on their lives. The goal of MDM is to maximize outcomes for the PWD without additional burden; this approach can be incorporated with the CCM and diabetes self-management to reduce complexity (22,23).

The National Standards are applicable to all care models, including solo practice, community, large practice, technology-enabled models of care, and others (24). The National Standards can provide structure and consistency to the coordination of care and population health. DSMES services are not limited to fee-for-service billing to the Centers for Medicare & Medicaid Services and can utilize other financial models, such as value-based payments and collaboration with commercial payers for sustainability (25,26).

DSMES services must be supported and broadly incorporated in emerging models of care, including Accountable Care Organizations, Patient-Centered Medical Homes, Population Health Programs, and value-based payment models (27–29). The National Standards are the basis for recognition by the ADA and accreditation by the ADCES, the two accrediting organizations certified by Medicare (30,31). The National Standards also serve as a guide for all members of the care team as well as insurance providers to ensure PWD receive DSMES services that are evidence-based and up to date.

The authors and collaborating organizations involved in the revision of the

2022 National Standards urge payers, physicians/other qualified healthcare professionals, advocates, and supporters of DSMES to acknowledge and address the evolving complexities within the healthcare landscape (3,32). This revision again reinforces the essential need for person-centered DSMES services offered throughout the life span of a PWD instead of a rigid program structure. The National Standards do not endorse any one approach, but rather seek to delineate the commonalities among effective and evidence-based DSMES strategies. Since the last revision, the terminology for the Diabetes Educator has changed to the Diabetes Care and Education Specialist. The Diabetes Care and Education Specialist is “A compassionate teacher and expert who, as an integral member of the care team, provides collaborative, comprehensive, and person-centered care and education for people with diabetes” (33,34). The new title more accurately reflects this range of diverse skills and specialization and conveys the broad clinical management skill set and the expanded role of technology. The Certification Board for Diabetes Care and Education also changed Certified Diabetes Educator (CDE) to Certified Diabetes Care and Education Specialist (CDCES) in recognition of this change and conveys the level of expertise held by those with this credential (33).

GUIDING PRINCIPLES FOR THE 2022 REVISION OF THE NATIONAL STANDARDS

Due to the dynamic nature of healthcare and diabetes research, the National Standards are reviewed and revised approximately every 5 years by key stakeholders and experts within the diabetes care and education community. For each revision, the Task Force is charged with reviewing the current National Standards for appropriateness, relevance, and scientific basis and making updates based on

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This article contains supplementary material online at <https://doi.org/10.2337/figshare.17049224>.

This article is featured in a podcast available at diabetesjournals.org/journals/pages/diabetes-core-update-podcasts.

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current evidence and expert consensus. In 2021, the group was tasked with reducing administrative burden related to DSMES implementation across diverse care settings. The goal is to increase health equity through access to this critical service while focusing more on person-centered care and decreasing the administrative complexities outlined in previous revisions. The group was also committed to increasing clarity in documentation requirements that enhance communication and continuity of services and reduce ambiguity across all DSMES care team members. As a result, the National Standards have been revised to reduce administrative burden while maintaining the highest quality services for PWD and decreasing burnout for all diabetes healthcare professionals, including the DSMES team. It must be acknowledged that some language contained in the 2022 National Standards revision is from the 2017 National Standards (35). A summary of changes in the 2022 National Standards revision can be found in Supplementary Material 1. For definitions of terms, the National Standards' Glossary can be found in Supplementary Material 2.

STANDARD 1: SUPPORT FOR DSMES SERVICES

The DSMES team will seek leadership support for implementation and sustainability of DSMES services. The sponsor organization will recognize and support quality DSMES services as an integral component of diabetes care. Sponsor organizations will provide guidance and support for DSMES services to facilitate alignment with organizational resources and the needs of the community being served.

Support from the sponsor organizations and internal leadership is crucial for the success of DSMES services. This is needed to overcome the low utilization of DSMES services due to various barriers (e.g., payer, healthcare system, physician/other qualified healthcare professional, individual, environmental, etc.) that impede access to and utilization of DSMES services (3). Support of DSMES services also involves inclusive healthcare teams, which at minimum, include the PWD, the referring physician/other qualified healthcare professional, and the diabetes care and education specialist. The inclusion of and communication between various healthcare team members, specifically diabetes

care and education specialists, has effectively improved diabetes care (20). Ultimately, organizational support of evidence-based DSMES is necessary to ensure that these services are available in the delivery method preferred and accessible and adequately utilized by the PWD. Support could also be from expert stakeholders, who can provide purposeful input and advocacy to promote awareness, value, access, increased utilization, and quality (36,37). Stakeholders can be identified from DSMES participants' referring physicians/other healthcare professionals (within and outside the organization), and community- and affinity-based groups that support DSMES (e.g., fitness clubs and social media networks).

STANDARD 2: POPULATION AND SERVICE ASSESSMENT

The DSMES service will evaluate their chosen target population to determine, develop, and enhance the resources, design, and delivery methods that align with the target populations' needs and preferences.

To best plan, design, deliver, evaluate, and improve quality of services, the DSMES team must identify and understand their target populations' demographics and SDOH (38). Demographic characteristics may include race, ethnic/cultural background, sex, age, geographic location, technology access, levels of formal education, literacy level, health literacy, and numeracy (39–41). The populations' perception of risk associated with diabetes, related complications, and co-occurring conditions (28,42,43) are also key characteristics to consider. 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.

It is essential to promote access to DSMES services by identifying and addressing population barriers and health inequities (3). Barriers may include socioeconomic, cultural factors, misaligned schedules, health insurance shortfalls, perceived lack of need, or limited encouragement from healthcare professionals to engage in DSMES (28,44,45). SDOH related to the target population should guide service design and delivery (46).

STANDARD 3: DSMES TEAM

All members of a DSMES team will uphold the National Standards and implement collaborative DSMES services, including evidence-based service design, delivery, evaluation, and continuous quality improvement. At least one team member will be identified as the DSMES quality coordinator and will oversee effective implementation, evaluation, tracking, and reporting of DSMES service outcomes.

The DSMES team may include one or a variety of healthcare professionals. The evidence recommends that inclusion of dietitians, nurses, pharmacists, or all other disciplines with special certifications that demonstrate mastery of diabetes knowledge and training, such as Board Certified in Advanced Diabetes Management (BC-ADM) and Certified Diabetes Care and Education Specialists (CDCES), can support all DSMES services, including clinical assessment (24,47).

The quality coordinator needs to ensure the DSMES services are person-centered and understand the process of identifying, analyzing, and communicating quality data. The quality coordinator may partner with other team members to support quality improvement. Although the quality coordinator does not require additional degrees or certifications in informatics, developing an understanding of these skills—as well as marketing, healthcare administration, and business management—will be helpful as the healthcare environment continues to evolve. The quality coordinator role may vary depending on the setting of the DSMES services and may or may not be part of the instructional team.

Other members of the healthcare team, including social workers, Certified Health Education Specialists (CHESs and MCHESs), Exercise Physiologists, Diabetes Community Care Coordinators (previously referred to as paraprofessionals in the 2017 National Standards), and others are also valuable members of the DSMES team. As DSMES team members, Diabetes Community Care Coordinators may include, but are not limited to community health workers, health promoters, dietetic technicians, medical assistants, pharmacy technicians, peer educators, and trained peer leaders. Diabetes Community Care Coordinator team members can provide basic instruction, reinforce self-management skills, support behavior change, facilitate group discussion, provide

psychosocial support, and provide ongoing self-management support (47,48).

To maintain competence and expertise in the expanding diabetes care and education services, all DSMES team members are required to participate in and have documented continuing education, specific to the role they serve within the team (24,47–49). For services outside of the scope of practice of the DSMES team or services, the DSMES team should document communication with referring physicians/other qualified healthcare professionals to support person-centered care.

STANDARD 4: DELIVERY AND DESIGN OF DSMES SERVICES

DSMES services will utilize a curriculum to guide evidence-based content and delivery, to ensure consistency of teaching concepts, methods, and strategies within the team, and to serve as a resource for the team. DSMES teams will have knowledge of and be responsive to emerging evidence, advances in education strategies, pharmacotherapeutics, technology-enabled treatment, local and online peer support, psychosocial resources, and delivery strategies relevant to the population they serve.

The options for delivery of DSMES have grown dramatically in recent years as technology has been incorporated into healthcare, and simultaneously as more people have become comfortable using technology for communication, teaching, and learning. Various modes of delivery can support increased communication between PWD and the DSMES team and improve diabetes-related outcomes. Strong evidence supports DSMES delivery through virtual, telehealth, telephone, text messaging, and web-based/mobile phone applications (apps) (50–55).

The most effective and evidence-based delivery methods move beyond the mere acquisition of knowledge to support informed decision making while addressing psychosocial concerns of the PWD (56,57). The use of interactive teaching styles that include meaningful discussions to address individual questions and needs while fostering a culture of positivity within the DSMES services is recommended. The curriculum content and delivery should be creative, culturally appropriate (58,59), and adapted as necessary for the individuals and groups within the target population (60–64). Furthermore, culturally

tailored services have been shown to be effective in improving diabetes care outcomes (59,65).

A curriculum provides guidance for the DSMES team, effective teaching strategies, and methods for evaluating learning outcomes and includes all aspects of diabetes self-management and support (66–68). DSMES delivery should integrate topics across content areas rather than creating silos of content that limit informed and wise decision making. The delivery of curriculum content must be dynamic and based on continuing assessment of need, preferences, and evaluation of outcomes (66,68–71). Recent education research endorses the inclusion of practical problem solving and self-advocacy approaches, as well as collaborative care, including family and peer support, addressing psychosocial issues, behavior change, diabetes devices, and strategies to sustain self-management efforts (21,24,65,72–78). The ADCE57 Self-Care Behaviors (i.e., healthy coping, healthy eating, being active, taking medication, monitoring, reducing risk, and problem solving) is an evidence-based framework and outline to provide and document diabetes care and education that can be used in conjunction with the chosen curricula (79). A DSMES curriculum must include the following core content areas, and content must be prioritized to meet the individual PWD's current needs and goals (3,15,80,81):

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

DSMES follow-up and ongoing support

While initial DSMES is necessary, it is not sufficient for sustaining a lifetime of diabetes self-management; initial improvements in outcomes have been shown to diminish 6 months after conclusion of the intervention (80). To maintain self-care behavior at the level needed to effectively sustain diabetes management over time, PWD benefit from ongoing diabetes self-management support. On-

going support helps PWD to implement and sustain the ongoing skills, knowledge, coping, and behavioral strategies needed to manage diabetes (3). Because family members, caregivers, and peers can be an effective resource for ongoing support but often don't know how to help, it can be beneficial to include family members and caregivers throughout the DSMES intervention (3). Connecting PWD to technology enabled solutions, such as mobile apps, digital therapeutics, online programs, and peer groups, within the local or online community can encourage practical integration of diabetes self-management and psychosocial support into the existing daily routine between and beyond DSMES sessions.

STANDARD 5: PERSON-CENTERED DSMES

Person-centered DSMES is a recurring process over the life span for PWD. Each person's DSMES plan will be unique and based on the person's concerns, needs, and priorities collaboratively determined as part of a DSMES assessment. The DSMES team will monitor and communicate the outcomes of the DSMES services to the diabetes care team and/or referring physician/other qualified healthcare professional.

To ensure that DSMES is addressing the current concerns, needs, and priorities of the PWD, referring physicians/other qualified healthcare professionals should assess the need for DSMES referral or follow-up at four critical times (3). The four critical times are at diagnosis, annually and/or when not meeting treatment targets, when complicating factors develop, and when transitions in life or care occur (3,66).

Every DSMES intervention should be a person-centered process that addresses timely education and supports individual needs throughout a person's lifetime (3,66,82,83). A DSMES intervention can include individual and/or group sessions and is initiated with an assessment of the PWD's current concerns, needs, and priorities to create a DSMES plan of care guided by the PWD's preferred delivery method and timing. The DSMES plan is implemented through a series of sessions, utilizing a variety of methods, while supporting and tracking related outcomes to identify trends and reinforce effective self-management behaviors (3,66,82). Communicating the progress and related outcomes to the

PWD's diabetes care team contributes to the continuum of person-centered collaborative care and assists in overcoming therapeutic inertia (66,84–86).

Assessment

To implement a person-centered DSMES plan, the Diabetes Care and Education Specialist must closely work in partnership with each PWD to better understand how (e.g., modality, content, and frequency) to best suit that person. The assessment process involves collaborative communication between a health-care professional and the PWD to 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 (15,87).

Examples of information gathered during the assessment process can include the following:

- Health status: type of diabetes, clinical needs, health history, disabilities, physical limitations, SDOH and health inequities (e.g., safe housing, transportation, access to nutritious foods, access to healthcare, financial status, and limitations), risk factors, comorbidities, and age
- Learning level: diabetes knowledge, health literacy, literacy, numeracy, readiness to learn, ability to self-manage, developmental stage, learning disabilities, cognitive/developmental disabilities (e.g., intellectual disability, moderate-severe autism, dementia), and mental health impairment (e.g., schizophrenia, suicidality)
- Lifestyle practices: self-management skills and behaviors, health service or resource utilization, cultural influences, alcohol and drug use, lived experiences, religion, and sexual orientation
- Psychosocial adjustment: emotional response to diabetes, diabetes distress, diabetes family support, peer support (e.g., in-person or via social networking sites), and other potential promoters and barriers (22,46,84,88–92)

This information can be provided by the PWD as well as obtained from the health record/electronic health record (EHR) and identified support persons or caregivers. This information should be reviewed by the DSMES team to inform and promote person-centered

understanding. The assessment process can be supported by a variety of collection/intake modalities, such as online assessments via consumer portals and EHR, tablet computers that integrate with EHR, text messaging, web-based tools, automated telephone follow-up, and remote monitoring tools (26,93–95). Although not an exhaustive list or applicable to all populations, examples of assessment tools can be found in Supplementary Material 3.

While it would be ideal to have all this information on or before the first session, the realities of the healthcare environment often require the DSMES team to conduct focused assessments in specific areas at the first session and throughout subsequent sessions of the intervention. After the initial assessment, ongoing assessments will be incremental over time based on individual need (3,96). A PWD's concerns and needs change throughout their lifetime due to changes in physical and emotional health, cultural and religious practices, SDOH, the ability to exercise, care support systems, etc. (46,84,89,96).

The assessment can also identify factors that affect the PWD's ability to effectively manage their diabetes that go beyond the scope of practice of the DSMES team. For example, DSMES services play a critical role in closing gaps in care by helping to facilitate necessary referrals (e.g., medical nutrition therapy, social work, psychology, pharmacy, podiatry, optometry, lab tests, specialists, etc.) beyond DSMES that increase access to resources to assist the PWD (88,97–100).

Implementing person-centered DSMES sessions

After the initial assessment, the PWD and DSMES team member(s) develop a person-centered DSMES plan. The ADCE57 Self-Care Behaviors (57) can be used as a base for documentation of the DSMES plan to promote continuity of care with all members of the DSMES team and across DSMES services.

The DSMES team member(s) use person-centered and strengths-based plain language (101), jargon-free and culturally relevant information, language- and literacy-appropriate educational materials (102), and interpreter services when indicated (103). Evidence-

based communication strategies, such as goal setting, action planning, empowerment-based principles and strategies, motivational interviewing, shared decision making, cognitive behavioral therapy, problem solving, self-efficacy enhancement, teach-back method, and relapse prevention strategies are also effective (76,104–107). The DSMES team uses nonjudgmental, nonstigmatizing, and gender-inclusive language when speaking and in writing with and about PWD.

The DSMES plan, topics covered at each session, and the outcomes of the intervention are documented in the DSMES record for each person. This documentation provides evidence of person-centered DSMES and communication among other members of the person's healthcare team. This enhances long-term management and continuity of diabetes care, education, and support (108). Using technology tools and EHRs, in turn, increase access to information for all team members to work collaboratively and have access to documentation (109).

Supporting and tracking person-centered self-management outcomes

Clinical outcome measures reflect the impact of the DSMES services on the health status of the PWD (110). To demonstrate the benefits of DSMES and/or the need for treatment plan adaptation, it is important for DSMES services to measure and track relevant individual outcomes, such as clinical outcomes, patient-reported outcomes, psychosocial outcomes, and behavioral outcomes. Use of patient-generated health data (PGHD) has rapidly increased with wearable devices and apps, and PGHD can assist in setting and tracking outcomes and goals. There is increasing adoption of PGHD diabetes devices, such as continuous glucose monitors (CGMs). For example, CGMs can assist PWD in setting and tracking behavioral and clinical outcomes with real-time feedback for indicators, such as glucose time in, below, or above range and glucose management indicator (111). Incorporating PGHD (112) into decision making individualizes self-management and empowers PWD to fully engage in personal problem solving toward evaluating and changing behaviors and improving outcomes (26,111,113–115).

It is crucial for each PWD to collaboratively develop action-oriented behavior

change plans to reach their personal behavioral goals, coping strategies, and treatment (or clinical) targets (87,116). The DSMES team will explain and demonstrate psychosocial and behavior change strategies that can be used by the PWD to meet their self-determined goals and targets (117). The role of the DSMES team is to provide support in problem solving during this process (118,119). The ADCE57 Self-Care Behaviors (57) can be used for tracking progress in behavior goals.

For some outcomes, the indicators, measures, and timeframes will depend on evidence-based guidelines from professional organizations or government agencies (15,120,121).

STANDARD 6: MEASURING AND DEMONSTRATING OUTCOMES OF DSMES SERVICES

DSMES services will have ongoing continuous quality improvement (CQI) strategies in place that measure the impact of the DSMES services. Systematic evaluation of process and outcome data will be conducted to identify areas for improvement and to guide services optimization and/or redesign.

To demonstrate the benefits of DSMES, members of the DSMES team track relevant individual PWD outcomes (STANDARD 5). Then, these individual outcomes are aggregated to report practice level population outcomes. The diabetes self-management education core outcomes measures (68) specify behavior change as a key outcome, and the ADCE57 Self-Care Behaviors provide a useful framework for assessment, documentation, and evaluation (3,57). The DSMES team should select validated instruments or assessment tools (see Supplementary Material 3) whenever possible and consider utilizing, contributing to, or reflecting upon assessment tools within their organization to accurately track progress and outcomes.

Service models that include population health and disease management, an interprofessional team, and ongoing social support improve both individual-level and aggregated practice-level outcomes (3,122). Formal CQI strategies provide a framework to strive for excellence, quantify successes, and identify future opportunities. In addition, formal CQI strategies are best informed through stakeholder input and have been shown to improve diabetes outcomes (123), which in turn may be used as evidence

to inform payment models and policy for support of DSMES services.

Quality improvement initiatives may target DSMES services at an individual practice, multicenter system, or national DSMES effort level (124). By measuring and monitoring both process and outcome data on an ongoing basis, the DSMES team can identify areas for improvement. They can then adjust engagement strategies and service offerings to optimize outcomes. Evaluation of reach, effectiveness, and adoption achieved via quality improvement initiatives generates evidence to support the business case for maintenance and/or expansion of the DSMES services. Positive results from quality initiatives can be used in marketing efforts and shared with administrators/leadership. A focus on quality is also part of overall healthcare quality initiatives. DSMES services can make a substantial impact on many of the measured outcomes, including the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) and the Quality Payment Program, which have shifted the focus of provider payment from unit of service to quality and outcomes. As an example of promoting quality as an outcome, participating clinicians can be rewarded based on annual predetermined quality measure data, and requirements may change each performance year (125).

Once areas for DSMES services improvement are identified, timelines for data collection with internal audits for verification of data integrity, analysis, and presentation of results can be established.

Outcomes are broadly considered as process data or outcomes data. Outcome data may be clinical, behavioral, patient-reported, and PGHD. Examples for each of these outcome types are provided in **Table 1**. Process outcomes indicate what a healthcare professional does to maintain or improve health (110). They provide information to inform what will lead to desired behavioral and clinical outcomes improvement (e.g., attendance at DSMES sessions, medication taking behaviors, or preventive services involvement) (126). Clinical outcomes indicate the result of the process (e.g., whether treatment or behavioral changes are leading to improvements, such as a change in A1C) and should align with the

greater organizational performance measures, when applicable.

Process outcome measures examine activities driving the most important outcomes of interest from the DSMES services perspective. Process outcome measures generally recommended for DSMES services are operational measures (e.g., characteristics of PWD receiving services, results of marketing efforts, attendance and factors impacting attendance, financial metrics including billing and reimbursement rates, copays, facility fees, PWD and physician/other qualified healthcare professional satisfaction, referrals to DSMES, and attainment rates for recommended diabetes-related surveillance testing). For DSMES services, SDOH must also be considered as process measures because addressing elements of SDOH are necessary for the PWD to achieve optimal self-management and are deemed essential to achieving health equity from the individual PWD, program, and population health perspectives (46).

A wide variety of methods can be used to guide quality improvement initiatives at the individual practice or system levels. The Institute for Healthcare Improvement suggests the Model for Improvement as a framework to guide improvement work (126). The model consists of three fundamental questions that should be answered by an improvement process: 1) "What are we trying to accomplish?" 2) "How will we know a change is an improvement?" and 3) "What changes can we make that will result in an improvement?" (126). Evidence-based examples of such methods include the Plan-Do-Study-Act model, Six Sigma, Lean, workflow mapping, the Re-AIM (127) framework, and the Chronic Care Model (128). There are resources available to assist those initiating quality improvement programs for the first time or for those looking for new options (21,123,126–129). The Centers for Disease Control and Prevention DSMES Technical Assistance Guide (129) and accompanying toolkit (130) also provide guidance for planning and implementing activities to increase use of DSMES services and address quality improvement components. Quality and Performance groups at hospitals and in health systems are also a resource for those embarking on DSMES services quality improvement efforts.

Table 1—DSMES Outcome Examples

| Outcome type | Example |
|---|--|
| Process outcomes | Referral process Attendance Education mapping Social determinants of health Timing of education sessions (e.g., times that meet the PWD needs) |
| Clinical outcomes | A1C Time in hypoglycemia Pregnancy outcomes LDL-cholesterol levels BMI and body weight Blood pressure Time in range |
| Psychosocial and behavioral outcomes (57) | Healthy coping Healthy eating Being active Taking medication Monitoring Reducing risk Problem solving |
| Patient-reported outcomes | Health-related quality of life Diabetes-related quality of life Diabetes distress Self-efficacy Functional status Patient satisfaction |
| Patient generated health data | Blood glucose trends CGM glucose management indicator Weight, activity, steps Food/beverage intake Sleep Blood pressure |

CONCLUSIONS

In keeping with the theme of MDM and recognition of the specialist role of the Diabetes Care and Education Specialist and CDCES, this revision of the National Standards focuses on clarifying key concepts and reducing administrative tasks associated with DSMES services that have little to no impact on person-centered outcomes. While the COVID-19 pandemic and public health emergency have had a major impact on healthcare systems, physicians/other qualified healthcare professionals, and PWD, it is imperative that evidence-based solutions are supported, and that every effort is made across government agencies, payers, and physicians/other qualified healthcare professionals to expand the role of and access to DSMES across the country. As we have learned from the disruption in all aspects of people's daily lives from the COVID-19 pandemic, it is clear that structured DSMES programs do not benefit everyone, and delivery of evidenced-

based, person-centered care is needed to drive quality outcomes. It also reinforces the importance of assessing diabetes distress and promoting the use of healthy coping strategies for effective self-management of diabetes. Alternative methods of delivery, such as one on one audio and audio-video contact, can also improve outcomes similar to in-person DSMES and allow the PWD to choose the option that best meets their needs and preferences.

Evidence supports an expanded role of the Diabetes Care and Education Specialist as an effective change agent in overcoming therapeutic inertia. Research studies show that Diabetes Care and Education Specialists can support intensification of treatment plans to achieve glycemic, blood pressure, and lipid targets through the implementation of diabetes management protocols (131). Furthermore, a recent systematic review and meta-analysis adds to the growing body of evidence that professionals who are not physicians, such as the Diabetes

Care and Education Specialist, are well positioned and should be empowered to initiate and intensify treatment plans when supported by appropriate guidelines (20). Use of digital technology (e.g., cloud-based, telehealth, data management platforms, apps, and social media) enhances the ability to employ a technology enabled self-management feedback loop with four key elements—two-way communication, analysis of PGHD, customized education, and person-centered feedback—to provide real-time engagement in self-management, as well as enable and empower PWD to effectively communicate with their care team (26). Disparities and inequities in access, adoption, and optimization of diabetes technology have become increasingly apparent in the COVID-19 pandemic (11). A framework identified specifically for Diabetes Care and Education Specialists to address these inequities that can be used as a practice model to aid in the incorporation of technology into their DSMES services is the ICC Framework (Identify, Configure, Collaborate) (132, 133). Data support that technology can aid in better outcomes; however, additional assessment and judgement to determine if there are barriers to use and if those barriers can be overcome must be considered (134,135). Other tools are available to assist with implementation and ongoing utilization of diabetes technology (111,136,137).

On a final note, implementation science is an emerging and cost-effective way to study real world methods that promote integration of research and evidence into practice and policy (138). DSMES is an area well established for healthcare professionals to utilize a robust body of evidence to evaluate outcomes, reduce costs, and decrease health disparities while addressing and reducing health inequities.

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Diabetes Self-Management Education and Support for Adults with Type 2 Diabetes: ALGORITHM ACTION STEPS

Four critical times to assess, provide, and adjust diabetes self-management education and support

| AT DIAGNOSIS | ANNUAL ASSESSMENT OF EDUCATION, NUTRITION, AND EMOTIONAL NEEDS | WHEN NEW COMPLICATING FACTORS INFLUENCE SELF-MANAGEMENT | WHEN TRANSITIONS IN CARE OCCUR |
|---|--|---|---|
| PRIMARY CARE PROVIDER/ENDOCRINOLOGIST/CLINICAL CARE TEAM: AREAS OF FOCUS AND ACTION STEPS | | | |
| <ul style="list-style-type: none"> <input type="checkbox"/> Answer questions and provide emotional support regarding diagnosis <input type="checkbox"/> Provide overview of treatment and treatment goals <input type="checkbox"/> Teach survival skills to address immediate requirements (safe use of medication, hypoglycemia treatment if needed, introduction of eating guidelines) <input type="checkbox"/> Identify and discuss resources for education and ongoing support <input type="checkbox"/> Make referral for DSME/S and medical nutrition therapy (MNT) | <ul style="list-style-type: none"> <input type="checkbox"/> Assess all areas of self-management <input type="checkbox"/> Review problem-solving skills <input type="checkbox"/> Identify strengths and challenges of living with diabetes | <ul style="list-style-type: none"> <input type="checkbox"/> Identify presence of factors that affect diabetes self-management and attain treatment and behavioral goals <input type="checkbox"/> Discuss impact of complications and successes with treatment and self-management | <ul style="list-style-type: none"> <input type="checkbox"/> Develop diabetes transition plan <input type="checkbox"/> Communicate transition plan to new health care team members <input type="checkbox"/> Establish DSME/S regular follow-up care |
| DIABETES EDUCATION: AREAS OF FOCUS AND ACTION STEPS | | | |
| <p>Assess cultural influences, health beliefs, current knowledge, physical limitations, family support, financial status, medical history, literacy, numeracy to determine which content to provide and how:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Medication – choices, action, titration, side effects <input type="checkbox"/> Monitoring blood glucose – when to test, interpreting and using glucose pattern management for feedback <input type="checkbox"/> Physical activity – safety, short-term vs. long-term goals/recommendations <input type="checkbox"/> Preventing, detecting, and treating acute and chronic complications <input type="checkbox"/> Nutrition – food plan, planning meals, purchasing food, preparing meals, portioning food <input type="checkbox"/> Risk reduction – smoking cessation, foot care <input type="checkbox"/> Developing personal strategies to address psychosocial issues and concerns <input type="checkbox"/> Developing personal strategies to promote health and behavior change | <ul style="list-style-type: none"> <input type="checkbox"/> Review and reinforce treatment goals and self-management needs <input type="checkbox"/> Emphasize preventing complications and promoting quality of life <input type="checkbox"/> Discuss how to adapt diabetes treatment and self-management to new life situations and competing demands <input type="checkbox"/> Support efforts to sustain initial behavior changes and cope with the ongoing burden of diabetes | <ul style="list-style-type: none"> <input type="checkbox"/> Provide support for the provision of self-care skills in an effort to delay progression of the disease and prevent new complications <input type="checkbox"/> Provide/refer for emotional support for diabetes-related distress and depression <input type="checkbox"/> Develop and support personal strategies for behavior change and healthy coping <input type="checkbox"/> Develop personal strategies to accommodate sensory or physical limitation(s), adapting to new self-management demands, and promote health and behavior change | <ul style="list-style-type: none"> <input type="checkbox"/> Identify needed adaptations in diabetes self-management <input type="checkbox"/> Provide support for independent self-management skills and self-efficacy <input type="checkbox"/> Identify level of significant other involvement and facilitate education and support <input type="checkbox"/> Assist with facing challenges affecting usual level of activity, ability to function, health benefits and feelings of well-being <input type="checkbox"/> Maximize quality of life and emotional support for the patient (and family members) <input type="checkbox"/> Provide education for others now involved in care <input type="checkbox"/> Establish communication and follow-up plans with the provider, family, and others |

Sample Flyer



YOU CAN THRIVE WITH DIABETES

Do you want to:

- Improve your blood sugar and A1c levels?
- Keep your blood pressure on target?
- Better manage your cholesterol numbers?
- Save money on diabetes supplies?

Then Diabetes Education can help!

Diabetes education will help you learn how to manage your diabetes and be as healthy as possible by focusing on seven self-care behaviors: healthy eating, being active, monitoring, taking medication, problem solving, healthy coping and reducing risks.

Diabetes educators are experienced healthcare professionals

– such as registered nurses, registered dietitians or pharmacists – who have special knowledge and skills to help you successfully manage all aspects of your diabetes. Like many people with diabetes, you may find managing the disease is difficult. That's where a diabetes educator can help, by working with you to design a specific plan that includes the tools and support you need.

Diabetes education works. Studies show that diabetes education helps people lower their blood sugar, blood pressure and cholesterol levels. These things help you stay healthier and reduce the risk of diabetes complications.

Find a diabetes education program in your area:

diabeteseducator.org/find

The best times for diabetes education are:

1. When you're diagnosed with diabetes
2. As part of your annual assessment of education, nutrition or emotional issues
3. When new complications arise
4. During changes in your healthcare team or treatment

Brought to you by:

 American Association
of Diabetes Educators
diabeteseducator.org

 American
Diabetes
Association.
diabetes.org

 Academy of Nutrition
and Dietetics
eatright.org

 NDEP
NDEP.nh.gov

ADA DSMES Support Plan

My Support Plan

Name _____

Date / /

Check the box of each support resource that is of interest to you.

General Diabetes Education

- Diabetes Online Community
beyondtype1.org/the-diabetes-online-community-doc
- 4 Steps to Manage Your Diabetes for Life
cdc.gov/diabetes/ndep/toolkits/4steps.html

Diabetes Magazines

- Diabetes Self-Management
diabetesselfmanagement.com
- Diabetes Health
diabeteshealth.com

Online Diabetes Magazines

- A Sweet Life
asweetlife.org
- diaTribe Foundation
diatribe.org/foundation

Online Mental/Emotional Health Resources

- Mental Health Provider Referral Directory
professional.diabetes.org/mhp_listing
- Diabetes and Mental Health
cdc.gov/diabetes/managing/mental-health.html

Online Nutrition/Healthy Eating Resources

- ADA Nutrition
diabetes.org/nutrition
- Diabetes Food Hub
diabetesfoodhub.org
- Calorie King
calorieking.com/us/en

Online Physical Activity Resources

- ADA Fitness
diabetes.org/fitness
- Make Your Workout Work for You
cdc.gov/features/diabetes-physical-activity/index.html

Smoking Cessation

- All About Quitting Smoking
professional.diabetes.org/pel/all-about-quitting-smoking-english-0

Support Groups

- Find Diabetes Support in the Community
diabetes.org/community
- Online Support Community
community.diabetes.org/home

Weight Management

- Taking Off Pounds Sensibly (TOPS)
tops.org
- WW (formerly Weight Watchers)
weightwatchers.com/us

Local Support Options

Nutrition

Physical Activity

Support Groups

Other Resources



Education
Recognition
Program

ADCES Sample Provider Letter

Sample Provider Letter

Dear <PROVIDER >,

We (I) are (am) writing to share information about diabetes self-management education and support (DSMES). Attached is a recent position statement about DSMES in type 2 diabetes. It was written jointly by the American Association of Diabetes Educators, American Diabetes Association and the Academy of Nutrition and Dietetics. These are all national organizations that support diabetes awareness, management and self-management education.

To summarize, this Joint Position Statement provides several evidence-based findings:

- Ongoing patient self-management education and support are critical to preventing acute complications and reducing the risk of long-term complications.
- Critical times when DSMES should be provided for type 2 diabetes, what is included at each of the time points for quality diabetes care and how best to provide DSMES in a patient-centered manner.
- Engaging adults with type 2 diabetes in DSMES results in statistically significant and clinically meaningful improvement in A1c.
- Healthcare communities responsible for delivering quality care need to mobilize efforts to address the barriers and explore resources for DSMES in order to meet the needs of adults living with and managing type 2 diabetes

We strongly encourage you to read the position document and accompanying algorithm and incorporate these recommendations when developing plans for people with diabetes. DSMES administered by trained professionals, combining group and individual counselling, has been shown statistically to improve outcomes.

(Insert your institution/ practice) employs certified diabetes educators (CDEs) who are (insert backgrounds of available staff). They can provide individual and group education centered on healthy eating, active living, glucose monitoring, medication, problem solving, healthy coping, reducing risks and information about the latest diabetes technologies.

To make a referral to the program, please call (insert phone number) or visit (insert email or website) for additional information.

Thanks for your dedication to the health of our community!

Sincerely,

(Insert key program leadership)

CDC Intervention Tailoring Worksheet



Tool 2 Intervention Tailoring Worksheet

Example Barriers to DSMES Participation

(build on your context assessment)

Example Tailoring Strategies

Financial Needs

Tailor DSMES services and examples to the socioeconomic status of participants—teach participants about affordable healthy food options.

Provide education on options for obtaining lower-cost diabetes medications, meters, and testing strips, such as using the clinic pharmacy.

Work with community partners to offer free support services, including cooking classes.

Language- and Literacy-Related Needs

Use plain language, visuals, and models to help participants grasp DSMES content (e.g., show the amount of sugar in one soda).

Work with bilingual educators or translators for non-English-speaking participants and offer education materials in participants' preferred language.
