



Diabetes Self-management Education and Support in Adults With Type 2 Diabetes: A Consensus Report of the American Diabetes Association, the Association of Diabetes Care and Education Specialists, the Academy of Nutrition and Dietetics, the American Academy of Family Physicians, the American Academy of PAs, the American Association of Nurse Practitioners, and the American Pharmacists Association

Margaret A. Powers, MS, RD, CDE; Joan K. Bardsley, MBA, RN, CDE, FADE; Marjorie Cypress, NP; Martha M. Funnell, MS, RN, CDE, FAAN; Dixie Harms, DNP, ARNP, FNP-C, BC-ADM, FAANP; Amy Hess-Fischl, MS, RD, LDN, BC-ADM, CDE; Beulette Hooks, MD; Diana Isaacs, PharmD, BCPS, BCACP, BC-ADM, CDE; Ellen D. Mandel, DMH, MPA, MS, PA-C, RDN, CDE; Melinda D. Maryniuk, MEd, RD, CDE, FADA; Anna Norton, MS; Joanne Rinker, MS, RDN, CDCES, LND, FADCES; Linda M. Siminerio, PhD, RN, CDE; Sacha Uelmen, RDN, CDE

Supplementary materials:
Supplementary Tables 1 and 2 are available at www.jandonline.org

DIABETES IS A COMPLEX AND challenging disease that requires daily self-management decisions made by the person with diabetes. Diabetes self-management education and support (DSMES) addresses the compre-

hensive blend of clinical, educational, psychosocial, and behavioral aspects of care needed for daily self-management and provides the foundation to help all people with diabetes navigate their daily self-care with confidence and improved outcomes.^{1,2}

The prevalence of diagnosed diabetes is projected to increase in the U.S. from 22.3 million (9.1% of the total population) in 2014, to 39.7 million (13%) in 2030, and to 60.6 million (17%) in 2060.³ Approximately 90–95% of those with diabetes have type 2 diabetes.⁴ Diabetes is an expensive disease, and the medical costs of health care alone for a person with diabetes are 2.3 times more than for a person without diabetes.⁵ Confronting the diabetes epidemic and high costs, therapeutic targets are not being met⁶. There is a lack of improvement in reaching clinical target goals since 2005 despite advancements in medication and technology treatment modalities. Indeed, between 2010 and 2016 improved outcomes stalled or reversed.⁶

The goals of this Consensus Report are to improve clinical care and education services, to improve the health of

individuals and populations, and to reduce diabetes associated per capita health care costs.^{1,7} This article is specifically directed toward health care providers (physicians, nurse practitioners, physician assistants [PAs]), referred to herein as providers, as it outlines the benefits of DSMES, defines four critical times to provide and modify DSMES (see the [Figure](#)), proposes how to locate DSMES related resources, and discusses potential solutions to access and utilization barriers. This report provides guidance to others as well: health systems and organizations can use this report to anticipate and address the needs of persons with diabetes and create access to DSMES services; persons with diabetes can increase their awareness of DSMES services as part of quality care and can advocate for self-management education and support; and payers and policy makers can work to design reimbursement processes that support participation in DSMES. The Consensus Report's recommendations are listed in [Table 1](#).

This Consensus Report focuses on a component of diabetes care that is

2212-2672/Copyright © 2020 American Diabetes Association, American Pharmacists Association, Academy of Nutrition and Dietetics, American Academy of Physician Assistants, American Association of Nurse Practitioners, and Association of Diabetes Care & Education Specialists. Published by Elsevier Inc. All rights reserved.
<https://doi.org/10.1016/j.jand.2020.04.020>

This article is being published simultaneously in Diabetes Care, The Diabetes Educator, the Journal of the Academy of Nutrition and Dietetics, the Journal of the American Academy of Physician Assistants, the Journal of the American Association of Nurse Practitioners, and the Journal of the American Pharmacists Association. See page 13 for additional resources.



Figure. The four critical times to provide and modify diabetes self-management education and support.

often not accessed or utilized effectively—DSMES. DSMES is identified as one of the essential elements of comprehensive diabetes medical care, along with medical nutrition therapy (MNT) (see **MEDICAL NUTRITION THERAPY AS A CORE COMPONENT OF QUALITY DIABETES CARE**). DSMES improves health outcomes and quality of life and is cost effective (see **BENEFITS ASSOCIATED WITH DSMES**). Current utilization is quite low because of a variety of barriers, yet solutions are available (see **PROVIDING DSMES AND IDENTIFYING AND ADDRESSING BARRIERS**). Solutions begin with an organizational commitment to the value of access to, and participation in, DSMES. Financial support for DSMES services is available yet requires special attention (see **REIMBURSEMENT**). Key stakeholders can use this Consensus Report and the current Standards of Medical Care in Diabetes from the American

Diabetes Association (ADA)⁸ to develop action plans for increased referral to and utilization of DSMES. These efforts are needed to increase the focus on achieving treatment targets early and maintaining them throughout a person's lifetime.

The purpose of DSMES is to give people with diabetes the knowledge, skills, and confidence to accept responsibility for their self-management. This includes collaborating with their health care team, making informed decisions, solving problems, developing personal goals and action plans, and coping with emotions and life stresses.⁹ This Consensus Report focuses on the particular needs of adults with type 2 diabetes. DSMES needs are critical to those living with type 1 diabetes, prediabetes, and gestational diabetes mellitus; however, the evidence and examples referred to in this Consensus Report are for adults with type 2 diabetes.

A call to action for all health care systems and organizations is to engage needed resources and to effectively and efficiently manage and address this expensive epidemic affecting health outcomes. We must address barriers that result in therapeutic inertia created by health policy, health systems, providers, people with diabetes, and the environment, including social determinants of health,¹⁰ which encompass the conditions in which people live, work, learn, and play.¹¹ Rather than being overwhelmed and nonattentive to this crisis, all stakeholders must be creative and responsive to the needs of all involved and make it their priority.

METHODS

This Consensus Report is an update of the 2015 joint position statement on DSMES.¹² The panel of experts authoring this report includes representatives from the three national organizations that jointly published the original article (ADA, American Association of Diabetes Educators [AADE], and Academy of Nutrition and Dietetics), and, in an effort to widen the reach and stakeholder input, the American Academy of Family Physicians, American Academy of PAs, American Association of Nurse Practitioners, American Pharmacists Association, and a patient advocate were invited to participate. At the beginning of the writing process all members of the expert panel participated in two surveys related to the 2015 joint position statement and its impact and the desired future use of this Consensus Report: one survey from their perspective and one completed while interviewing colleagues. The expert panel agreed on the direction for this Consensus Report, established writing teams to author the various sections of the report, and reviewed the entire updated manuscript after each step. An outside market research company was used to conduct the literature search and was paid using ADA funds. Monthly calls were held between March 2019 and December 2019, with additional e-mail and web-based collaboration. Two in-person meetings were conducted to provide organization to the process, establish the review process, reach consensus on the content and key definitions (see **Table 2**), and discuss

Table 1. DSMES Consensus Report recommendations

DSMES improves health outcomes, quality of life, and is cost effective, and people with diabetes deserve the right to DSMES services. Therefore, it is recommended that:

Providers

1. Discuss with all persons with diabetes the benefits and value of initial and ongoing DSMES.
2. Initiate referral to and facilitate participation in DSMES at the 4 critical times: 1) at diagnosis, 2) annually and/or when not meeting treatment targets, 3) when complicating factors develop, and 4) when transitions in life and care occur.
3. Ensure coordination of the medical nutrition therapy plan with the overall management strategy, including the DSMES plan, medications, and physical activity on an ongoing basis.
4. Identify and address barriers affecting participation with DSMES services following referral.

Health policy, payers, health systems, providers, and health care teams

5. Expand awareness, access, and utilization of innovative and nontraditional DSMES services.
6. Identify and address barriers influencing providers' referrals to DSMES services.
7. Facilitate reimbursement processes and other means of financial support in consideration of cost savings related to the benefits of DSMES services.

and deliberate the recommendations. Once the draft was completed, the structured peer review process was implemented and the report was sent to two additional representatives from each of the seven participating organizations. A final draft was completed and submitted to all seven national organizations for final review and approval. The recommendations are the informed, expert consensus of the seven contributing organizations.

BENEFITS ASSOCIATED WITH DSMES

Consensus recommendation

- Providers should discuss with all persons with diabetes the benefits and value of initial and ongoing DSMES.

The benefits of DSMES are multifaceted and include clinical, psychosocial, and behavioral outcomes benefits. Key clinical benefits are improved hemoglobin A_{1c} (A1C) with reductions that are additive to lifestyle and drug therapy.^{13–16} Based on recent data,^{13,14,16} DSMES results in an average A1C reduction of 0.45–0.57% when compared with usual care for people with type 2 diabetes treated with a variety of modalities (lifestyle alone, oral and injected medication),^{13–17} as well as reduction in the onset and/or worsening of diabetes-related

complications^{18,19} and reduction of all-cause mortality.²⁰ DSMES improves quality of life^{15,21–23} and promotes lifestyle behaviors including healthful meal planning and engagement in regular physical activity.²⁴ In addition, participation in DSMES services shows enhancement of self-efficacy and empowerment,²⁵ increased healthy coping,²⁶ and decreased diabetes related distress.²⁷ These improvements clearly affirm the importance and benefits of utilizing DSMES and justify efforts to facilitate participation as a necessary part of quality diabetes care. **Table 3** highlights the multiple and varied benefits that make DSMES services a critical component of quality diabetes care and compares its effects to metformin therapy.¹⁷

Evidence supports that better health outcomes are associated with an increased amount of time spent with a diabetes care and education specialist.^{13,28,29} People with diabetes who completed more than 10 h of DSMES over the course of 6–12 months and those who participated on an ongoing basis were found to have significant reductions in mortality²⁰ and A1C (average absolute reduction of 0.57%)¹⁶ compared with those who spent less time with a diabetes care and education specialist.

Research shows that those who participate in diabetes education are more likely to use best practices and have lower health care costs.^{28,30} Even though outpatient and pharmacy costs are higher for those who use diabetes education, these costs are offset by

lower acute care costs.²⁸ DSMES is cost-effective by reducing emergency department visits, hospital admissions, and hospital readmissions.^{28,30–33} The cost of diabetes in the U.S. in 2017 was reported to be \$327 billion including direct medical costs (\$176 billion) and lost productivity (\$69 billion).⁵ The cost of care for people with diabetes accounts for about one in four health care dollars spent in the U.S.; 61% of costs are attributed to people over age 65 and are incurred by Medicare.⁵

The U.S. health care system cannot sustain the costs of care associated with the increasing incidence of diabetes and diabetes-related complications. DSMES offers a pathway to decrease these costs and improve outcomes.

DSMES improves quality of life and health outcomes and is cost-effective. All members of the health care team and health systems should promote the benefits, emphasize the value, and support participation in initial and ongoing DSMES for all people with diabetes (see **Table 4**).

PROVIDING DSMES

Consensus recommendation

- Health policy, payers, health systems, providers, and health care teams need to expand awareness, access, and utilization of innovative and nontraditional DSMES services.

Table 2. Key definitions

Diabetes self-management education and support (DSMES)

- *DSMES*⁴⁰: The ongoing process of facilitating the knowledge, skills, and ability necessary for diabetes self-management as well as activities that assist a person in implementing and sustaining the behaviors needed to manage his or her condition on an ongoing basis, beyond or outside of formal self-management training. This process incorporates the needs, goals, and life experiences of the person with diabetes.
- *Support*⁴⁰: Helps implement informed decision making, self-management behaviors, problem solving, and active collaboration with the health care team to improve clinical outcomes, health status, and quality of life.

Note: Diabetes services and specialized providers and educators often provide both education and support. Yet on-going support from the primary health care team, family and friends, specialized home services, and the community are necessary to maximize implementation of needed self-management.

Note: CMS uses the term “training” (DSMT) instead of “education” (DSMES) when defining the reimbursable Medicare benefit. Education is used in the National Standards for Diabetes Self-Management Education and Support and more commonly used in practice. In the context of this article, the terms have the same meaning.

Person-centered care⁹⁶

- Providing care and education that is respectful of and responsive to an individual person’s preferences, needs, and values and ensuring that those values guide all clinical decisions.

Diabetes-related distress^{23,26,97}

- Diabetes-related distress is defined as the emotional burden of diabetes, the constant demands from diabetes self-management (taking and adjusting medications, monitoring blood glucose, meal planning, and physical activity) and the possibility of developing complications, and the lack of support and access to care.
- The emotional burden of diabetes has the greatest impact on diabetes distress and outcomes.

Diabetes care and education specialist (DCES)⁹⁸

- A trusted expert of the integrated care team who provides collaborative, comprehensive, and person-centered care and education to persons with diabetes and related cardiometabolic conditions.

Note: In 2019 a new title to identify health professionals who specialize in diabetes care and education was created by the Association of Diabetes Care and Education Specialists. Clinical staff who qualify for this title may or may not be a CDCES or BC-ADM, yet all who hold the CDCES and BC-ADM certifications are diabetes care and education specialists. Certified Diabetes Care and Education Specialist (CDCES)⁹⁹

- A health care professional who has completed a minimum number of hours in clinical diabetes practice, passed the Certification Examination for Diabetes Care and Education (administered by the Certification Board for Diabetes Care and Education [CBDCE]), and has responsibilities that include the direct provision of diabetes education.

Note: The Certified Diabetes Educator (CDE) certification title is now CDCES.

Board Certified-Advanced Diabetes Management (BC-ADM)¹⁰⁰

- A health care professional who has completed a minimum number of hours in advanced diabetes management, holds a graduate degree, passed the BC-ADM certification exam (administered by the Association of Diabetes Care & Education Specialists), and has responsibilities of an increased complexity of decision making related to diabetes management and education.

Social determinants of health^{11,83}

- The conditions in which people live, work, learn, play, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems.

A variety of DSMES approaches and settings need to be presented and discussed with people with diabetes, thus enabling self-selection of a method that best meets their specific needs.³⁴ Historically, DSMES services were

provided in a formal series of didactic classes where people with diabetes and their family members participated at a hospitalbased/ health care facility location. Evolving health care delivery systems, primary care needs, and the

needs of people with diabetes have resulted in the incorporation of DSMES services into additional and nontraditional settings such as those located within patient-centered medical homes, community health centers,

Table 3. Comparing the benefits of DSMES/MNT vs. metformin therapy¹⁷

Criteria	Benefits Rating	
	DSMES/MNT	Metformin
Efficacy	High Low	High Low
Hypoglycemia risk Weight	Neutral/loss	Neutral/loss
Side effects	None	Gastrointestinal
Cost	Low/savings	Low
Psychosocial benefits*	High	N/A

N/A, not applicable. *Psychosocial benefits include *improvements* to quality of life, self-efficacy, empowerment, healthy coping, knowledge, self-care behaviors, meal planning, healthier food choices, more activity, use of glucose monitoring, lower blood pressure and lipids and *reductions* in problems in managing diabetes, diabetes distress, and the risk of long-term complications (and prevention of acute complications).

pharmacies, and accountable care organizations (ACOs), as well as faith-based organizations and home settings.

Technology-based services including web-based programs, telehealth, mobile applications, and remote monitoring enable and promote increased access and connectivity for ongoing management and support.³⁵ Recent health care concerns are rapidly expanding the use of these services, especially telehealth. In conjunction with formal DSMES, online peer support communities are growing in popularity. Involvement in these groups can be a beneficial adjunct to learning, serving as an option for ongoing diabetes peer support^{36,37}

(Supplementary Table 1, available at www.jandonline.org).

Creative, person-centered approaches to meet individual needs that consider various learning preferences, literacy, numeracy, language, culture, physical challenges, scheduling challenges, social determinants of health, and financial challenges should be widely available. It is important to ensure access in communities at highest risk for diabetes, such as racial and ethnic minorities and underserved communities.

Office-based health care teams without in-house resources can partner with local diabetes care and education specialists within their community to explore opportunities to reach people

with diabetes and overcome some barriers to participation at the point of care.³⁸ If the office-based care team assumes responsibility for providing diabetes education and support, every effort should be made to ensure they receive up-to-date training in diabetes care and education and utilize the details in Tables 5 and 6.

Regardless of the DSMES approach or setting, personalized and comprehensive methods are necessary to promote effective self-management required for day-to-day living with diabetes. Effective delivery involves expertise in clinical, educational, psychosocial, and behavioral diabetes care.^{39,40} It is essential for the referring provider to mutually establish personal treatment plans and clinical goals with the person with diabetes and communicate these to the DSMES team. Ongoing communication and support of recommendations and progress toward goals between the person with diabetes, education team, referring provider, and other members of the health care team are critical.

A person-centered approach to DSMES beginning at diagnosis of diabetes provides the foundation for current and future decisions. Without the focus on a person's beliefs and desires, ongoing treatment goals can rarely be met. Diabetes self-management is not a static process and requires ongoing assessment and modification, as identified by the four critical times (see the Figure). Initial and ongoing DSMES helps the person overcome barriers and cope with the enduring and changing demands throughout the continuum of diabetes treatment and life transitions.

Providers and other members of the immediate health care team have an important role in providing education and ongoing support for self-management needs. New behaviors can be difficult to maintain and require reinforcement at a minimum of every 6 months.⁴¹ In addition to the providers, the care team may include diabetes care and education specialists (DCES); registered dietitian nutritionists (RDNs); nutrition and dietetics technicians, registered (NDTRs); nurse educators; care managers; pharmacists; exercise and rehabilitation specialists; and behavioral or mental health care providers. In addition, others have a role in helping to sustain the benefits

Table 4. Summary of DSMES benefits to discuss with people with diabetes^{15-28,30-33,40,89}

- Provides critical education and support for implementing treatment plan
- Reduces emergency department visits, hospital admissions, and hospital readmissions
- Reduces hypoglycemia
- Reduces all-cause mortality
- Lowers A1C
- Promotes lifestyle behaviors including healthful meal planning and engagement in regular physical activity
- Addresses weight maintenance or loss
- Enhances self-efficacy and empowerment
- Increases healthy coping
- Decreases diabetes-related distress
- Improves quality of life

No negative side effects

Medicare and most insurers cover the costs

gained from DSMES, including community health workers, nurses, care managers, trained peers, home health care service workers, social workers, and mental health counselors and other support people (e.g., family members).^{42–46} Professional associations may help identify specific services in the local area such as the Visiting Nurse Association and block nurse programs (see [Supplementary Table 1](#), available at www.jandonline.org).

Family members and peers are an underutilized resource for ongoing support and often struggle with how to best provide help.^{47,48} Including family members in the DSMES process can help facilitate their involvement.^{49–51} Such support people can be especially helpful and serve as cultural navigators in health care systems and as liaisons to the community.⁵² Community programs such as healthy cooking classes, walking groups, peer support communities, and faith-based groups may lend support for implementing healthy behavior changes, promoting emotional health, and meeting personal health goals.¹²

All health care providers and/or systems need to identify adequate resources available in their respective communities, demonstrate commitment to support these services, and offer them as part of quality diabetes care. Health care providers need to be aware of the DSMES resources in their health system and communities and make appropriate referrals.

FOUR CRITICAL TIMES TO REFER TO DSMES

Consensus recommendation

- Providers should initiate referral to and facilitate participation in DSMES at the four critical times 1) at diagnosis, 2) annually and/or when not meeting treatment targets, 3) when complicating factors develop, and 4) when transitions in life and care occur.

There are four critical times to provide and modify DSMES: 1) at

diagnosis, 2) annually and/or when not meeting treatment targets, 3) when complicating factors develop, and 4) when transitions in life and care occur. These critical times are moments when people with diabetes may need the most assistance to achieve and/or adjust their goals and care plans for successful daily self-management. Although these four critical times are listed, it is important to recognize diabetes is a chronic disease that progresses over time and requires vigilant care to meet changing physiologic needs and goals.⁵³

The existing treatment plan may become ineffective due to changing situations that can arise at any time. Such situations include progression of the disease, changes in personal goals, unmet targets, major life changes, or new barriers identified when assessing social determinants of health.

It is prudent to be proactive when changes are identified or emerging. Additional support from the entire care team and referral to DSMES are appropriate responses to any of these needs. Quality ongoing, routine diabetes care includes continuous assessment, ongoing education and learning, self-management planning, and ongoing support.

The AADE7 Self-Care Behaviors provide the overarching framework for identifying key components of education and support.⁵⁴ The seven self-care behaviors are healthy coping, healthy eating, being active, taking medication, monitoring, reducing risks, and problem solving. Mastery of skills and behaviors related to each of these areas requires practice and experience. Often, a series of ongoing education and support visits are necessary to allow participants the time to practice new skills and behaviors, to develop problem-solving skills, and to improve their ability and self-efficacy to set and reach personal self-management goals.⁵⁵ Targeted questions, such as those now used in social determinants of health surveys utilized by many organizations, systems, and credentialed DSMES programs, can identify and facilitate addressing the immediate needs of the person with diabetes⁵⁶ and/or facilitate referral to the most appropriate team member (see [Table 7](#)).

Care and education plans at each of the four critical times focus on the

needs and personal goals of the individual. Therefore, the plan should be based on personal experiences that are relevant to self-management and applicable to personal goals, treatment targets, and objectives and acknowledge that adults possess expertise about their own lives.⁵⁷ [Tables 5](#) and [6](#) serve as checklists to ensure clinical teams and health systems offer necessary diabetes services (factors that indicate DSMES needs and what DSMES provides).

1. AT DIAGNOSIS

For an individual and family, the diagnosis of diabetes is often overwhelming,^{58,59} with fears, anger, myths, and personal, family, and life circumstances influencing this reaction. Immediate care addresses these concerns through listening, providing emotional support, and answering questions. Providers typically first set the stage for a lifetime chronic condition that requires focus, hope, and resources to manage on a daily basis. A person-centered approach at diagnosis is essential for establishing rapport and developing a personal and feasible treatment plan.

Despite the wide range of knowledge and skills that are required to self-manage diabetes, caution should be taken to not confound the overwhelming nature of the diagnosis but to determine what the person needs from the care team at this time to safely navigate self-management during the first days and weeks. Responses to such questions as shown in [Table 7](#) (also see [Tables 5](#) and [6](#)) guide and set direction for each person. Immediate referral to DSMES services establishes a personal education and support plan and highlights the value of initial and ongoing education. Initial DSMES at diagnosis typically includes a series of visits or contacts to build on clinical, psychosocial, and behavioral needs. See [Table 6](#) for suggested content.

Education at diagnosis focuses on safety concerns, often referred to as survival-level skills education, and addresses “what do I need to do once I leave your office?” To begin the process of managing the diagnosis and incorporating self-management into daily life, a diabetes care and education specialist and/or other members of the

Table 5. Factors that indicate referral to DSMES services is needed

At diagnosis	<ul style="list-style-type: none"> • Newly diagnosed—all newly diagnosed people with type 2 diabetes should receive DSMES • Ensure that both nutrition and emotional health are appropriately addressed in education or make separate referrals
Annually and/or when not meeting treatment targets	<ul style="list-style-type: none"> • Review of knowledge, skills, psychosocial, and behavioral outcomes or factors that inhibit or facilitate achievement of treatment target and goals • Long-standing diabetes with limited prior education • Treatment ineffective for attaining therapeutic target • Change in medication, activity, or nutritional intake or preferences • Maintenance of clinical and quality of life outcomes • Unexplained hypoglycemia or hyperglycemia • Support to attain or sustain improved behavioral or psychosocial outcomes
When complicating factors develop	<p>Change in:</p> <ul style="list-style-type: none"> • Health conditions, such as renal disease and stroke, need for steroids, or complicated medication plan • Health status requiring changes in nutrition, physical activity, etc. • Planning pregnancy or pregnant • Physical limitations such as cognitive impairment, visual impairment, dexterity issues, movement restrictions • Emotional factors such as diabetes distress, anxiety, and clinical depression • Basic living needs such as access to shelter, food, health care, medicines, and financial limitations
When transitions in life and care occur	<p>Change in:</p> <ul style="list-style-type: none"> • Living situation such as inpatient or outpatient or other change in living situation (i.e., living alone, with family, assisted living, etc.) • Clinical care team • Initiation or intensification of insulin, new devices or technology, and other treatment changes • Insurance coverage that results in treatment change (i.e., provider changes, changes in medication coverage) • Age-related changes affecting cognition, vision, hearing, self-management, etc.

health care team work closely with the person with diabetes and his or her family members and/or significant others to answer questions, address initial concerns, and provide support and referrals to needed resources.

It is recommended that all persons with diabetes be offered a referral for individualized MNT with a registered dietitian nutritionist (RD/RDN) knowledgeable and skilled in diabetes-specific MNT and a mental health assessment, as indicated, from qualified providers with expertise in diabetes management⁶⁰ (see [Supplementary Table 1](#), available at www.jandonline.org). These team members are critical at all four critical times.

Important discussions at diagnosis include the natural history of type 2 diabetes, what the journey will involve in terms of lifestyle and possibly medication, and acknowledgment that a range of emotional responses is common. Emphasizing the importance of involving family members and/or significant others in ongoing education and support is also a key part of the process.^{47–51} Diabetes is largely self-managed and care management involves trial and error. The role of the health care team is to provide information and discuss effective strategies to reach chosen treatment targets and goals. The many tasks of self-management are not easy, yet worth the effort⁶¹ (see [BENEFITS ASSOCIATED WITH DSMES](#)).

2. ANNUALLY AND/OR WHEN NOT MEETING TREATMENT TARGETS

The health care team and others support the adoption and maintenance of daily self-management tasks,^{8,40} as many people with diabetes find sustaining these behaviors difficult. They need to identify education and other needs expeditiously in order to address the nuances of self-management and highlight the value of ongoing education. [Table 6](#) provides details of DSMES at this critical time. Annual assessment of knowledge, skills, and behaviors is necessary for those who achieve diabetes treatment targets and personal goals as well as for those who do not.

Primary care visits for people with diabetes typically occur every 3–6

Table 6. Checklist for providing and modifying DSMES at four critical times

Four critical times	Primary care provider/endocrinologist/clinical care team's role in diabetes education	Diabetes care and education specialist's role in diabetes education
At diagnosis (series of visits)	<ul style="list-style-type: none"> • Answer questions and provide emotional support regarding diagnosis • Shared decision-making of treatment and treatment targets • Teach survival skills to address immediate requirements (safe use of medication, hypoglycemia treatment if needed, introduction of eating guidelines) • Identify and discuss resources for education and ongoing support • Make referrals for DSMES and MNT 	<ul style="list-style-type: none"> • Assess cultural influences, social determinants of health, health beliefs, current knowledge, physical limitations, family support, financial and work status, medical history, learning preferences and barriers, literacy, and numeracy to determine which content to provide and how • Medication - choices, access, action, titration, side effects • Monitoring blood glucose - when to check, interpreting and using glucose pattern management for feedback • Physical activity - safety, short-term vs. long-term goals/recommendations • Preventing, detecting, and treating acute and chronic complications • Nutrition - food plan, planning meals, purchasing food, preparing meals, portioning food • Risk reduction - smoking cessation, foot care, cardiac risk • Developing personal strategies to address psychosocial issues and concerns; adjusting to a life with diabetes • Developing personal strategies to promote health and behavior change • Problem identification and solutions • Identifying and accessing resources
Annually and/or when not meeting treatment targets	<ul style="list-style-type: none"> • Refer for new techniques, technology, and updated information • Assess and refer if self-management targets not met to address barriers to self-care 	<ul style="list-style-type: none"> • Review and reinforce treatment goals and self-management needs • Review barriers to treatment effectiveness • Emphasize reducing risk for complications and promoting quality of life • Discuss how to adjust diabetes treatment and self-management to life situations and competing demands • Support efforts to sustain initial behavior changes and cope with the ongoing burden of diabetes

(continued on next page)

months.⁶⁰ These visits are opportunities to assess all areas of self-management, including laboratory results, and a review of behavioral changes and coping strategies, problem-solving skills, strengths and

challenges of living with diabetes, use of technology, questions about medication therapy and lifestyle changes, and other environmental factors that might impact self-management.⁴⁰ It is challenging for primary care providers

to address all assessments during a visit, which points to the need to utilize established DSMES resources and champion new ones to meet these needs, ensuring personal goals are met. See [Table 5](#) for indications for referral.

Table 6. Checklist for providing and modifying DSMES at four critical times (*continued*)

Four critical times	Primary care provider/endocrinologist/clinical care team's role in diabetes education	Diabetes care and education specialist's role in diabetes education
When complicating factors develop	<ul style="list-style-type: none"> Identify presence of factors that inhibit or facilitate achievement of treatment targets and personal goals Discuss impact of complications and successes with treatment and self-management 	<ul style="list-style-type: none"> Provide support for the provision of self-management skills in an effort to delay progression of the disease and prevent new complications Provide/refer for emotional support for diabetes-related distress and depression Develop and support personal strategies for behavior change and healthy coping Develop personal strategies to accommodate sensory or physical limitation(s), adapt to new self-management demands, and promote health and behavior change
When transitions in life and care occur	<ul style="list-style-type: none"> Develop diabetes transition plan Communicate transition plan to new health care team members Establish DSMES regular follow-up care 	<ul style="list-style-type: none"> Adjust diabetes self-management plan as needed Provide support for independent self-management skills and self-efficacy Identify level of significant other involvement and facilitate education and support Assist with facing challenges affecting usual level of activity, ability to function, health benefits and feelings of well-being Maximize quality of life and emotional support for the person with diabetes (and family members) Provide education for others now involved in care Establish communication and follow-up plans with the provider, family, and others Develop goals and personal strategies to promote health and behavioral change and improve quality of life

Possible barriers to achieving treatment goals, such as financial and psychosocial issues, life stresses, diabetes-related distress, fears, side effects of medications, misinformation, cultural barriers, or misperceptions, should be assessed and addressed. People with diabetes are sometimes unwilling or embarrassed to discuss these problems unless specifically asked.^{62,63}

Frequent DSMES visits may be needed when the individual is starting a new diabetes medication such as insulin,⁶⁴ is experiencing unexplained hypoglycemia or hyperglycemia, has worsening clinical indicators, or has unmet goals. Importantly, diabetes care and education specialists are charged

with communicating the revised plan to the referring provider and assisting the person with diabetes in implementing the new treatment plan.

3. WHEN COMPLICATING FACTORS DEVELOP

The identification of diabetes-related complications or other individual factors that may influence self-management should be considered a critical indicator of the need for DSMES that requires immediate attention and adequate resources. During clinical care, the provider may identify factors other than diabetes that may influence the individual's diabetes treatment and

associated self-management plan (see [Tables 5 and 6](#)). These factors may require a change in self-management or affect an individual's ability to manage their diabetes and may involve additional medications, new physical limitations, and/or new emotional needs. Examples could include a new diagnosis of renal disease or visual impairment, starting steroids, planning pregnancy, and/or psychosocial factors such as depression and anxiety.

The diagnosis of other health conditions often makes management more complex and adds additional tasks onto daily management. DSMES addresses the integration of multiple medical conditions into overall care

Table 7. Sample questions to guide a person-centered assessment⁵⁶

- How is diabetes affecting your daily life and that of your family?
- What questions do you have?
- What are one to two positive things you are doing right now to manage your diabetes?
- What is the hardest part about your diabetes right now, causing you the most concern, or is most worrisome to you about your diabetes?
- How can we best help you?

with a focus on maintaining or appropriately adjusting medication, meal plans, and physical activity levels to maximize outcomes and quality of life. In addition to the need to adjust or learn new self-management skills, effective coping, defined as a positive attitude toward diabetes and self-management, positive relationships with others, and enhanced quality of life are addressed in DSMES services.^{16,26} Focused emotional support may be needed for anxiety, stress, and diabetes-related distress and/or depression.

The progression of diabetes can increase the emotional and treatment burden of diabetes and distress.^{65,66} Diabetes-related distress, which is distinct from major depressive disorder, is particularly common, with overall prevalence rates reported to be 36%.⁶⁷ It has a greater impact on behavioral and metabolic outcomes than does depression.⁶⁶ Diabetes-related distress is responsive to intervention, including DSMES-focused interventions⁶⁸ and family support.⁴⁹ However, additional mental health resources are generally required to address severe diabetes-related distress, clinical depression, and anxiety.⁶⁵ It is important to recognize the psychological issues related to diabetes and prescribe treatment as appropriate.

4. WHEN TRANSITIONS IN LIFE AND CARE OCCUR

Throughout the life span many factors such as aging, living situation, schedule changes, or health insurance coverage may require a re-evaluation of diabetes treatment and self-management needs (see [Tables 5 and 6](#)). Critical transition periods may include transitioning into adulthood, living on one's own, hospitalization, and moving into an assisted

living or skilled nursing facility, correctional facility, or rehabilitation center. They may also include life milestones: marriage, divorce, becoming a parent, moving, death of a loved one, starting or completing college, loss of employment, starting a new job, retirement, and other life circumstances. Changing health care providers can also be a time at which additional support is needed.

DSMES affords important benefits to people with diabetes during transitions in life and care. Providing input into the development of practical and realistic self-management and treatment plans can be an effective asset for successful navigation of changing situations.

The health care provider can make a referral to a diabetes care and education specialist to add input to the transition plan, provide education and problem solving, and support successful transitions. The goal is to minimize disruptions in therapy during any transition, while addressing clinical, psychosocial, and behavioral needs.

MEDICAL NUTRITION THERAPY AS A CORE COMPONENT OF QUALITY DIABETES CARE

Consensus recommendation

- Providers should ensure coordination of the medical nutrition therapy plan with the overall management strategy, including the DSMES plan, medications, and physical activity on an ongoing basis.

MNT can reduce A1C by up to 2%, making it an essential component of initial and ongoing diabetes care.^{1,69,70} Additionally, MNT helps prevent,

delay, or treat other complications commonly found with diabetes such as hypertension, cardiovascular disease, renal disease, celiac disease, and gastroparesis. MNT provided by an RD/RDN is costeffective, and people who have received MNT show improved clinical outcomes and quality of life.⁶⁹ MNT is integral to quality diabetes care and should be incorporated into the overall care plan, medication plan, and DSMES plan on an ongoing basis.^{1,40,69–72} ([Table 8](#)).

Referral to the RD/RDN for MNT along with DSMES is recommended as a separate and distinct service provided by an RD/RDN. Although basic nutrition content is covered as part of DSMES, people with diabetes need both initial and ongoing MNT and DSMES; referrals to both can be made through many electronic health records as well as through hard copy or faxed referral methods (see [Supplementary Table 1](#) [available at www.jandonline.org] for specific resources).

Everyday decisions about what to eat must be driven by evidence and personal, cultural, religious, economic, and other preferences and needs.^{69–71} With an in-depth understanding of a person's food intake, factors influencing eating behaviors, coping strategies related to stress, and nutrition goals, the RD/RDN can work closely with the health care team to attain treatment goals, optimize medication management, or minimize the need for medications to meet glycemic targets and support progress toward other goals influenced by food intake.

The entire health care team should provide consistent messages and recommendations regarding nutrition therapy and its importance as a foundation for quality diabetes care based on national recommendations.⁷⁰ Ongoing collaboration and communication with RD/RDNs can facilitate this

aspect of care and support self-management and everyday food decisions.

IDENTIFYING AND ADDRESSING BARRIERS

Consensus recommendations

- Providers should identify and address barriers affecting participation with DSMES services following referral.
- Health policy, payers, health systems, providers, and health care teams should identify and address barriers influencing providers' referrals to DSMES services.

Despite the proven value and effectiveness of DSMES, a looming threat to its success is low utilization due to a variety of barriers. In order to reduce barriers, a focus on processes that streamline referral practices must be implemented and supported system wide. Once this major barrier is

addressed, the diabetes care and education specialist can be invaluable in addressing other barriers that the person may have. Without this, it will be increasingly difficult to access DSMES services, particularly in rural and underserved communities. With focus and effort, the challenges can be addressed and benefits realized.

The Centers for Disease Control and Prevention reported that only 6.8% of privately insured individuals with newly diagnosed type 2 diabetes participated in DSMES within 12 months of diagnosis.⁷³ Furthermore, the Centers for Medicare and Medicaid Services (CMS) state that only 5% of Medicare participants receive DSMES during the first year of diagnosis.⁷⁴ This low initial participation in DSMES was also reported in a recent AADE practice survey, with most people engaging in a diabetes program diagnosed for more than a year.⁷⁵ These low numbers are seen even in areas where cost is less of a barrier because of national health insurance. Analysis of National Health Service data in the U.K. reveals that only 8% of those referred to formal diabetes education, an annually reviewed standard of care, attended. This highlights the need to identify and

utilize resources that address all barriers including those related to health systems, health care providers, participants, and the environment. In addition, efforts are being made by national organizations to correct the identified access and utilization barriers.

Health system or programmatic barriers include lack of administrative leadership support, limited numbers of diabetes care and education specialists, geographic location, limited or lack of access to services, referral to DSMES services not effectively embedded in the health system service structure, limited resources for marketing, and limited or low reimbursement rates.⁷⁶ DSMES services should be designed and delivered with input from the target population and critically evaluated to ensure they are patient-centered.

Despite the value and proven benefits of these services, barriers within the benefit design of Medicare and other insurance programs limit access. Using Medicare as an example, some of these barriers include the following: hours allowed in the first year the benefit is used and subsequent years are predefined and not based on individual needs; a referral is required and

Table 8. Overview of MNT: an evidence-based application of the nutrition care process provided by the RDN^{1,40,69-72}

1. Characteristics of MNT reducing A1C by 0.5-2% for type 2 diabetes:

- Initial series of MNT encounters
- 3-6 during first 6 months of diagnosis
- Determine if more encounters are needed based on a personal assessment and person's goals

MNT follow-up encounters are based on needs

- Health care team assesses needs at critical times and makes referrals - change in medication, health status, schedule, activity, stress, access to food, need for on-going support, etc.
- Minimum of one annual follow-up encounter
- Key areas of focus and action steps for positive outcomes: persons with diabetes should have knowledge of food plan, planning meals, purchasing food, preparing meals, and portioning food. If they are not confident in these areas it is difficult to take advantage of the full impact of nutrition therapy. Implementation and assessment will drive confidence

2. MNT provides nutrition assessment, nutrition diagnosis, and an intervention and management plan including the creation of personal food plan and support

- Development of food plan/physical activity/medication dosing for improved postprandial glucose level, hypoglycemia prevention, and overall glycemic improvement
- Ongoing weight management planning and coaching
- Development of food plan for managing related complications and comorbidities such as hypertension, celiac disease, gastroparesis, eating disorders/disordered eating, kidney disease, disorders of lipid metabolism, etc.

Note: The Academy of Nutrition and Dietetics recognizes the use of registered dietitian (RD) and registered dietitian nutritionist (RDN). RD and RDN can only be used by those credentialed by the Commission on Dietetic Registration.

must be made by the primary provider managing diabetes; there is a requirement of diabetes diagnosis using methods other than A1C; and costly copays and deductibles apply. A person cannot have Medicare DSMES and MNT visits either face to face or through telehealth on the same day, thus requiring separate days to receive both of these valuable services and possibly delaying questions, education, and support.

Referring health care providers' barriers include lack of awareness of DSMES services, limitations of referring providers to those providing ongoing treatment of diabetes, misunderstanding of the necessity and effectiveness of DSMES, confusion regarding when and how to make referrals, and inconvenient or limited access.^{77–80} Referrals may also be limited by unconscious or implicit bias, which perpetuates health care disparities and leads to therapeutic inertia. The provider may too quickly judge an individual's potential to benefit from DSMES⁸¹ and may incorrectly assume the person's willingness/ability to participate. To address these barriers, providers can meet with those currently providing DSMES services in their area to better understand the benefits, access, and referral processes and to develop collaborative partnerships.

Participant-related barriers include logistical factors such as cost, timing, transportation, and medical status.^{34,77,78,82} For those who avail themselves of DSMES services, few complete their planned education due to such factors. The 2017 AADE practice survey of over 4,696 diabetes educators reported that only 23% of participants in diabetes education services completed 75% or more of the program.⁷⁵ Underutilization of services may be because of a lack of understanding or knowledge of the benefits, cultural factors, a desire to keep diabetes private due to perceived stigma and shame, lack of family support, and perceptions that the standard program did not meet their needs and is not relevant for their life, and the referring providers may not emphasize the value and benefits of initial and on going DSMES.^{34,79,80,82}

Health systems, clinical practices, people with diabetes, and those providing DSMES services can

collaborate to identify solutions to the barriers to utilization of DSMES for the population they serve. Creative and innovative solutions include offering a variety of DSMES options that meet individual needs within a population such as telehealth formats, coaching programs, just-in-time services, online resources, discussion groups, and intense programs for select groups, while maximizing community resources related to supporting healthy behaviors.

Credentialed DSMES programs as well as individual diabetes care and education specialists perform a comprehensive assessment of needs for each participant, including factors contributing to social determinants of health such as food access, financial means, health literacy and numeracy, social support systems, and health beliefs and attitudes. This allows the diabetes care and education specialist to individualize a plan that meets the needs of the person with diabetes and provide referrals to resources that address those factors that may not be directly addressed in DSMES. It is best that all potential participants are not funneled into a set program; classes based on a person-centered curriculum designed to address social determinants of health and self-determined goal setting can meet the varied needs of each person.

Environment-related barriers include limited transportation services and inadequate offerings to meet the various cultural, language, and ethnic needs of the population. Additionally, these types of barriers include those related to social determinants of health—the economic, environmental, political, and social conditions in which one lives.⁸³ The health system may be limited in changing some of these conditions but needs to help each person navigate their situation to maximize their choices that affect their health. It is important to recognize that some individuals are less likely to attend DSMES services, including those who are older, male, nonwhite, less educated, of lower socioeconomic status, and with clinically greater disease severity.^{84,85} Further, studies support the importance of cultural considerations in achieving successful outcomes.^{84–87} Solutions include exploring community resources to address factors that affect health

behaviors, providing seamless referral and access to such programs, and offering flexible programing that is affordable and engages persons from many backgrounds and living situations. The key is creating community-clinic partnerships that provide the right interventions, at the right time, in the right place, and using the right workforces.⁸⁸

REIMBURSEMENT

Consensus recommendation

- Health policy, payers, health systems, providers, and health care teams need to facilitate reimbursement processes and other means of financial support in consideration of cost savings related to the benefits of DSMES services.

Several common payment models and newer emerging models that reimburse for DSMES services are described below. For a list of diabetes education codes that can be submitted for reimbursement, see [Supplementary Table 2](#) (available at www.jandonline.org) (Billing codes to maximize return on investment (ROI) in diabetes care and education).

CMS has reimbursed diabetes education services billed as diabetes self-management training since 2001.^{40,89} DSMES services must receive accreditation by one of the current national accrediting organizations (Association of Diabetes Care & Education Specialists and ADA) to be eligible for reimbursement. In order to meet the requirements, DSMES services must adhere to National Standards for Diabetes Self-Management Education and Support and meet the billing provider requirements.^{40,89}

Ten hours are available for the first year of receiving this benefit and 2 h in subsequent years. Any provider (physician, nurse practitioner, PA) who is the primary provider of diabetes treatment can make a referral; there is a copay to use these services.

CMS also reimburses for diabetes MNT, which expands access to needed education and support. Three hours are

available the first year of receiving this benefit and 2 h are available in subsequent years. A physician can request additional MNT hours through an MNT referral that describes why more hours are needed, such as a change in diagnosis, medical condition, or treatment plan. There are no specific limits set for additional hours. There is no copayment or need to meet a Part B deductible in order to use these services. Many other payers also provide reimbursement for diabetes MNT.⁹⁰ Additional discipline-specific counseling that further enhances DSMES includes medication therapy management delivered by pharmacists and psychosocial counseling offered by mental health professionals, also reimbursed through CMS and/or thirdparty payers.^{40,77}

Reimbursement by private payers is highly variable. Many will match CMS guidelines, and those who recognize the immediate and longer-term cost savings associated with DSMES will expand coverage, sometimes with no copay.

With the transition to value-based health care, organizations may receive financial returns if they meet specified quality performance measures. Diabetes is typically part of a set of contracted quality measures impacting the payment model. Health systems should maximize the benefits of DSMES and factor them into the potential financial structure.

There are reimbursable billing codes available for remote monitoring of blood glucose and other health parameters that are related to diabetes. The use of devices that can monitor glucose, blood pressure, weight, and sleep allow the health care team to review the data, provide intervention, and recommend treatment changes remotely.

Sample referral forms that provide the information required by CMS and other payers for referral to DSMES and MNT are available along with reimbursement resources (see [Supplementary Tables 1 and 2](#), available at www.jandonline.org). These or similar forms can be embedded into an electronic health record for easy referral.

Health systems and clinical organizations can maximize billing potential by facilitating the reimbursement process, ensuring all applicable codes are

being utilized and submitted appropriately. This usually requires support from those who frequently work with health care codes such as staff in billing and compliance departments. Shared medical appointments can be performed with DSMES and they are reimbursable medical visits.

CONCLUSIONS

This Consensus Report is a resource for the entire health care team and describes the four critical times to refer to DSMES services with very specific recommendations for ensuring that all adults with diabetes receive these benefits. Diabetes is a complex condition that requires the person with diabetes to make numerous daily decisions regarding their self-management. DSMES delivered by qualified personnel using best practice methods has a profound effect on the ability to effectively undertake these responsibilities and is supported by strong evidence presented in this report. DSMES has a positive effect on clinical, psychosocial, and behavioral aspects of diabetes. DSMES provides the foundation with ongoing support to promote achievement of personal goals and influence optimal outcomes. Despite proven benefits and demonstrated value of DSMES, the number of people with diabetes who are referred to and receive DSMES is significantly low.^{73–75} Barriers will not disappear without intentional, holistic interventions recognizing the roles of the entire health care team, individuals with diabetes, and systems in overcoming issues of therapeutic inertia.¹⁰ The increasing prevalence of type 2 diabetes requires accountability by all stakeholders to ensure these important services are available and utilized.

The U.S. health care system has changed with increased attention on primary care, technology, and quality measures.⁹¹ DSMES services that directly connect with primary care are effective in improving clinical, psychosocial, and behavioral outcomes.^{92–95}

This changing health care environment provides a platform to use DSMES services as an effective, cost saving, high-impact resource integral to a person's ability to self-manage diabetes. A variety of culturally appropriate services need to be offered in a variety of settings, utilizing technology

to facilitate access to DSMES services, support self-management decisions, and decrease therapeutic inertia.

Additional resources are available at www.diabeteseducator.org/consensusreport. *Diabetes Care* (<https://doi.org/10.2337/dci20-0023>). *The Diabetes Educator* (<https://doi.org/10.1177/0145721720930959>). *Journal of the Academy of Nutrition and Dietetics* (<https://doi.org/10.1016/j.jand.2020.04.020>). *Journal of the American Academy of Physician Assistants* (<https://doi.org/10.1097/01.JAA.0000668828.47294.2a>). *Journal of the American Association of Nurse Practitioners* (<https://doi.org/10.1097/JXX.0000000000000473>). *Journal of the American Pharmacists Association* (<https://doi.org/10.1016/j.japh.2020.04.018>).

References

- American Diabetes Association. 5. Facilitating behavior change and well-being to improve health outcomes: *Standards of Medical Care in Diabetes—2020*. *Diabetes Care*. 2020;43(Suppl.1):S48–S65.
- Davies MJ, D'Alessio DA, Fradkin J, et al. Management of hyperglycemia in type 2 diabetes, 2018. A consensus report by the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD). *Diabetes Care*. 2018;41:2669–2701.
- Lin J, Thompson TJ, Cheng YJ, et al. Projection of the future diabetes burden in the United States through 2060. *Popul Health Metr*. 2018;16:9.
- American Diabetes Association. 2. Classification and diagnosis of diabetes: *Standards of Medical Care in Diabetes—2020*. *Diabetes Care*. 2020;43(Suppl. 1):S14–S31.
- American Diabetes Association. Economic costs of diabetes in the U.S. in 2017. *Diabetes Care*. 2018;41:917–928.
- Kazemian P, Shebl FM, McCann N, Walensky RP, Wexler DJ. Evaluation of the cascade of diabetes care in the United States, 2005–2016. *JAMA Intern Med*. 2019;179:1376–1385.
- Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Aff (Millwood)*. 2008;27:759–769.
- American Diabetes Association. *Standards of Medical Care in Diabetes—2020*. *Diabetes Care*. 2020;43(Suppl. 1):S1–S212.
- Funnell MM. Patient empowerment: what does it really mean? *Patient Educ Couns*. 2016;99:1921–1922.
- American Diabetes Association. Overcoming therapeutic inertia [Internet]. Accessed 3 September 2019. Available from, <https://professional.diabetes.org/meeting/other/overcoming-therapeutic-inertia>.
- Centers for Disease Control and Prevention. Social determinants of health [Internet]. 2019 Accessed 30 March 2020. Available from, <https://www.cdc.gov/socialdeterminants/index.htm>.

12. Powers MA, Bardsley J, Cypress M, et al. Diabetes self-management education and support in type 2 diabetes: a joint position statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics. *Diabetes Care*. 2015;38:1372-1382.
13. Steinsbekk A, Rygg LØ, Lisulo M, Rise MB, Fretheim A. Group based diabetes self-management education compared to routine treatment for people with type 2 diabetes mellitus. A systematic review with meta-analysis. *BMC Health Serv Res*. 2012;12:213.
14. Tshiananga JKT, Kocher S, Weber C, Erny Albrecht K, Berndt K, Neeser K. The effect of nurse-led diabetes self-management education on glycosylated hemoglobin and cardiovascular risk factors: a meta-analysis. *Diabetes Educ*. 2012;38:108-123.
15. Deakin T, McShane CE, Cade JE, Williams RDRR. Group based training for self-management strategies in people with type 2 diabetes mellitus. *Cochrane Database Syst Rev*. 2005;(2):CD003417.
16. Chvala CA, Sherr D, Lipman RD. Diabetes self-management education for adults with type 2 diabetes mellitus: a systematic review of the effect on glycemic control. *Patient Educ Couns*. 2016;99:926-943.
17. Powers MA. 2016 Health Care & Education Presidential Address: If DSME were a pill, would you prescribe it? *Diabetes Care*. 2016;39:2101-2107.
18. Diabetes Control and Complications Trial Research Group Nathan DM, Genuth S, Lachin J, et al. The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. *N Engl J Med*. 1993;329:977-986.
19. Stratton IM, Adler AI, Neil HAW, et al. Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): prospective observational study. *BMJ*. 2000;321:405-412.
20. He X, Li J, Wang B, et al. Diabetes self-management education reduces risk of all-cause mortality in type 2 diabetes patients: a systematic review and meta-analysis. *Endocrine*. 2017;55:712-731.
21. Cooke D, Bond R, Lawton J, et al; U.K. NIHR DAFNE Study Group. Structured type 1 diabetes education delivered within routine care: impact on glycemic control and diabetes-specific quality of life. *Diabetes Care*. 2013;36:270-272.
22. Cochran J, Conn VS. Meta-analysis of quality of life outcomes following diabetes self-management training. *Diabetes Educ*. 2008;34:815-823.
23. Toobert DJ, Glasgow RE, Strycker LA, et al. Biologic and quality-of-life outcomes from the Mediterranean Lifestyle Program: a randomized clinical trial. *Diabetes Care*. 2003;26:2288-2293.
24. Toobert DJ, Strycker LA, King DK, Barrera M Jr, Osuna D, Glasgow RE. Long-term outcomes from a multiple-risk-factor diabetes trial for Latinas: ¡Viva Bien!. *Transl Behav Med*. 2011;1:416-426.
25. Tang TS, Funnell MM, Oh M. Lasting effects of a 2-year diabetes self-management support intervention: outcomes at 1-year follow-up. *Prev Chronic Dis*. 2012;9:E109.
26. Thorpe CT, Fahey LE, Johnson H, Deshpande M, Thorpe JM, Fisher EB. Facilitating healthy coping in patients with diabetes: a systematic review. *Diabetes Educ*. 2013;39:33-52.
27. Fisher L, Hessler D, Glasgow RE, et al. REDEEM: a pragmatic trial to reduce diabetes distress. *Diabetes Care*. 2013;36:2551-2558.
28. Duncan I, Ahmed T, Li QE, et al. Assessing the value of the diabetes educator. *Diabetes Educ*. 2011;37:638-657.
29. Pillay J, Armstrong MJ, Butalia S, et al. Behavioral programs for type 2 diabetes mellitus: a systematic review and network meta-analysis. *Ann Intern Med*. 2015;163:848-860.
30. Robbins JM, Thatcher GE, Webb DA, Valdmanis VG. Nutritionist visits, diabetes classes, and hospitalization rates and charges: the Urban Diabetes Study. *Diabetes Care*. 2008;31:655-660.
31. Strawbridge LM, Lloyd JT, Meadow A, Riley GF, Howell BL. One-year outcomes of diabetes self-management training among Medicare beneficiaries newly diagnosed with diabetes. *Med Care*. 2017;55:391-397.
32. Healy SJ, Black D, Harris C, Lorenz A, Dungan KM. Inpatient diabetes education is associated with less frequent hospital readmission among patients with poor glycemic control. *Diabetes Care*. 2013;36:2960-2967.
33. Nassar CM, Montero A, Magee MF. Inpatient diabetes education in the real world: an overview of guidelines and delivery models. *Curr Diab Rep*. 2019;19:103.
34. Horigan G, Davies M, Findlay-White F, Chaney D, Coates V. Reasons why patients referred to diabetes education programmes choose not to attend: a systematic review. *Diabet Med*. 2017;34:14-26.
35. Greenwood DA, Gee PM, Fatkin KJ, Peoples M. A systematic review of reviews evaluating technology-enabled diabetes self-management education and support. *J Diabetes Sci Technol*. 2017;11:1015-1027.
36. Litchman ML, Rothwell E, Edelman LS. The diabetes online community: older adults supporting self-care through peer health. *Patient Educ Couns*. 2018;101:518-523.
37. Litchman ML, Walker HR, Ng AH, et al. State of the science: a scoping review and gap analysis of diabetes online communities. *J Diabetes Sci Technol*. 2019;13:466-492.
38. Siminerio L, Hamm M, Kanter J, Cameron FA, Krall J. A diabetes education model in primary care: provider and staff perspectives. *Diabetes Educ*. 2019;45:498-506.
39. Bowen ME, Rothman RL. Multidisciplinary management of type 2 diabetes in children and adolescents. *J Multidiscip Healthc*. 2010;3:113-124.
40. Beck J, Greenwood DA, Blanton L, et al; 2017 Standards Revision Task Force. 2017 National Standards for Diabetes Self-Management Education and Support. *Diabetes Care*. 2017;40:1409-1419.
41. Norris SL, Lau J, Smith SJ, Schmid CH, Engelgau MM. Self-management education for adults with type 2 diabetes: a meta-analysis of the effect on glycemic control. *Diabetes Care*. 2002;25:1159-1171.
42. Tang TS, Funnell M, Sinco B, et al. Comparative effectiveness of peer leaders and community health workers in diabetes self-management support: results of a randomized controlled trial. *Diabetes Care*. 2014;37:1525-1534.
43. Thom DH, Ghorob A, Hessler D, De Vore D, Chen E, Bodenheimer TA. Impact of peer health coaching on glycemic control in low-income patients with diabetes: a randomized controlled trial. *Ann Fam Med*. 2013;11:137-144.
44. Tang TS, Ayala GX, Cherrington A, Rana G. A review of volunteer-based peer support interventions in diabetes. *Diabetes Spectr*. 2011;24:85-98.
45. Funnell MM. Peer-based behavioural strategies to improve chronic disease self-management and clinical outcomes: evidence, logistics, evaluation considerations and needs for future research. *Fam Pract*. 2010;27(Suppl. 1):i17-i22.
46. Heisler M. Overview of peer support models to improve diabetes self-management and clinical outcomes. *Diabetes Spectr*. 2007;20:214-221.
47. Kovacs Burns K, Nicolucci A, Holt RIG, et al; DAWN2 Study Group. Diabetes Attitudes, Wishes and Needs second study (DAWN2™): cross-national benchmarking indicators for family members living with people with diabetes. *Diabet Med*. 2013;30:778-788.
48. Peyrot M, Burns KK, Davies M, et al. Diabetes Attitudes Wishes and Needs 2 (DAWN2): a multinational, multi-stakeholder study of psychosocial issues in diabetes and person-centred diabetes care. *Diabetes Res Clin Pract*. 2013;99:174-184.
49. Lee AA, Piette JD, Heisler M, Rosland A-M. Diabetes distress and glycemic control: the buffering effect of autonomy support from important family members and friends. *Diabetes Care*. 2018;41:1157-1163.
50. Whitehead L, Jacob E, Towell A, Abu-Qamar M, Cole-Heath A. The role of the family in supporting the self-management of chronic conditions: A qualitative systematic review. *J Clin Nurs*. 2018;27:22-30.
51. Lee AA, Piette JD, Heisler M, Janevic MR, Langa KM, Rosland A-M. Family members' experiences supporting adults with chronic illness: a national survey. *Fam Syst Health*. 2017;35:463-473.
52. Pearson TL, Bardsley J, Weiner S, Kolb L. Population health: the diabetes educator's evolving role. *Diabetes Educ*. 2019;45:333-348.
53. Childs BP, Cypress M, Spollett G, eds. *Complete Nurse's Guide to Diabetes Care*.

- 3rd ed. Arlington, VA: American Diabetes Association; 2017.
54. American Association of Diabetes Educators. An effective model of diabetes care and education: revising the AADE7 Self-Care Behaviors®. *Diabetes Educ.* 2020;46:139-160.
 55. Coulter A, Entwistle VA, Eccles A, Ryan S, Shepperd S, Perera R. Personalised care planning for adults with chronic or long-term health conditions. *Cochrane Database Syst Rev.* 2015;(3):CD010523.
 56. Funnell MM, Bootle S, Stuckey HL. The Diabetes Attitudes, Wishes and Needs second study. *Clin Diabetes.* 2015;33:32-36.
 57. Peters AL, Laffel L; American Diabetes Association; ; JDRF. *American Diabetes Association/JDRF Type 1 Diabetes Sourcebook.* Alexandria, VA: American Diabetes Association; 2013.
 58. Skovlund SE, Peyrot M. The Diabetes Attitudes, Wishes, and Needs (DAWN) program: a new approach to improving outcomes of diabetes care. *Diabetes Spectr.* 2005;18:136-142.
 59. Nicolucci A, Kovacs Burns K, Holt RIG, et al; DAWN2 Study Group. Diabetes Attitudes, Wishes and Needs second study (DAWN2™): cross-national benchmarking of diabetes-related psychosocial outcomes for people with diabetes. *Diabet Med.* 2013;30:767-777.
 60. American Diabetes Association. 4. Comprehensive medical evaluation and assessment of comorbidities: *Standards of Medical Care in Diabetes—2020.* *Diabetes Care.* 2020;43(Suppl. 1):S37-S47.
 61. Weiss MA, Funnell MM. In the beginning: setting the stage for effective diabetes care. *Clin Diabetes.* 2009;27:149-151.
 62. Beverly EA, Ganda OP, Ritholz MD, et al. Look who's (not) talking: diabetic patients' willingness to discuss self-care with physicians. *Diabetes Care.* 2012;35:1466-1472.
 63. Ritholz MD, Beverly EA, Brooks KM, Abrahamson MJ, Weinger K. Barriers and facilitators to self-care communication during medical appointments in the United States for adults with type 2 diabetes. *Chronic Illn.* 2014;10:303-313.
 64. Yehl K. AADE Practice Paper in Brief: Diabetes educators play a critical role in successful insulin management. *AADE Pract.* 2018;6:36-37.
 65. Young-Hyman D, de Groot M, Hill-Briggs F, Gonzalez JS, Hood K, Peyrot M. Psychosocial care for people with diabetes: a position statement of the American Diabetes Association. *Diabetes Care.* 2016;39:2126-2140.
 66. Peyrot M, Rubin RR, Lauritzen T, Snoek FJ, Matthews DR, Skovlund SE. Psychosocial problems and barriers to improved diabetes management: results of the Cross-National Diabetes Attitudes, Wishes and Needs (DAWN) Study. *Diabet Med.* 2005;22:1379-1385.
 67. Perrin NE, Davies MJ, Robertson N, Snoek FJ, Khunti K. The prevalence of diabetes-specific emotional distress in people with type 2 diabetes: a systematic review and meta-analysis. *Diabet Med.* 2017;34:1508-1520.
 68. Gonzalvo JD, Hamm J, Eaves S, et al. A practical approach to mental health for the diabetes educator. *AADE Pract.* 2019;7:29-44.
 69. Franz MJ, MacLeod J, Evert A, et al. Academy of Nutrition and Dietetics nutrition practice guideline for type 1 and type 2 diabetes in adults: systematic review of evidence for medical nutrition therapy effectiveness and recommendations for integration into the nutrition care process. *J Acad Nutr Diet.* 2017;117:1659-1679.
 70. Evert AB, Dennison M, Gardner CD, et al. Nutrition therapy for adults with diabetes or prediabetes: a consensus report. *Diabetes Care.* 2019;42:731-754.
 71. Marincic PZ, Hardin A, Salazar MV, Scott S, Fan SX, Gaillard PR. Diabetes self-management education and medical nutrition therapy improve patient outcomes: a pilot study documenting the efficacy of registered dietitian nutritionist interventions through retrospective chart review. *J Acad Nutr Diet.* 2017;117:1254-1264.
 72. Briggs Early K, Stanley K. Position of the Academy of Nutrition and Dietetics: The role of medical nutrition therapy and registered dietitian nutritionists in the prevention and treatment of prediabetes and type 2 diabetes. *J Acad Nutr Diet.* 2018;118:343-353.
 73. Li R, Shrestha SS, Lipman R, Burrows NR, Kolb LE, Rutledge S; Centers for Disease Control and Prevention (CDC). Diabetes self-management education and training among privately insured persons with newly diagnosed diabetes—United States, 2011–2012. *MMWR Morb Mortal Wkly Rep.* 2014;63:1045-1049.
 74. Strawbridge LM, Lloyd JT, Meadow A, Riley GF, Howell BL. Use of Medicare's diabetes self-management training benefit. *Health Educ Behav.* 2015;42:530-538.
 75. Rinker J, Dickinson JK, Litchman ML, et al. The 2017 diabetes educator and the Diabetes Self-Management Education National Practice Survey. *Diabetes Educ.* 2018;44:260-268.
 76. Carey ME, Agarwal S, Horne R, Davies M, Slevin M, Coates V. Exploring organizational support for the provision of structured self-management education for people with type 2 diabetes: findings from a qualitative study. *Diabet Med.* 2019;36:761-770.
 77. Centers for Disease Control and Prevention. Diabetes Self-Management Education and Support (DSMES) Toolkit [Internet], 2018 Accessed 3 September 2019. Available from <https://www.cdc.gov/diabetes/dsmes-toolkit/index.html>.
 78. Peyrot M, Rubin RR, Funnell MM, Siminerio LM. Access to diabetes self-management education: results of national surveys of patients, educators, and physicians. *Diabetes Educ.* 2009;35:246-248, 252–256, 258–263.
 79. Lawal M, Woodman A, Fanghanel J, Ohl M. Barriers to attendance at diabetes education centres: perceptions of education providers. *J Diabetes Nurs.* 2017;21:61-66.
 80. Azam LS, Jackson TA, Knudson PE, Meurer JR, Tarima SS. Use of secondary clinical data for research related to diabetes self-management education. *Res Social Adm Pharm.* 2017;13:494-502.
 81. Chapman EN, Kaatz A, Carnes M. Physicians and implicit bias: how doctors may unwittingly perpetuate health care disparities. *J Gen Intern Med.* 2013;28:1504-1510.
 82. Winkley K, Ewrierhoma C, Amiel SA, Lempp HK, Ismail K, Forbes A. Patient explanations for non-attendance at structured diabetes education sessions for newly diagnosed type 2 diabetes: a qualitative study. *Diabet Med.* 2015;32:120-128.
 83. World Health Organization. About social determinants of health [Internet]. Accessed 28 January 2020. Available from http://www.who.int/social_determinants/sdh_definition/en/.
 84. Harris S, Mulnier H, Amiel S. The Barriers to Uptake of Diabetes Education study (Abstract). *Lancet.* 2017;389:S44.
 85. Ross S, Benavides-Vaello S, Schumann L, Haberman M. Issues that impact type-2 diabetes self-management in rural communities. *J Am Assoc Nurse Pract.* 2015;27:653-660.
 86. Gonzales KL, Lambert WE, Fu R, Jacob M, Harding AK. Perceived racial discrimination in health care, completion of standard diabetes services, and diabetes control among a sample of American Indian women. *Diabetes Educ.* 2014;40:747-755.
 87. Jones V, Crowe M. How people from ethnic minorities describe their experiences of managing type-2 diabetes mellitus: a qualitative metasynthesis. *Int J Nurs Stud.* 2017;76:78-91.
 88. Hill-Briggs F. 2018 Health Care & Education Presidential Address: The American Diabetes Association in the era of health care transformation. *Diabetes Care.* 2019;42:352-358.
 89. Centers for Medicare & Medicaid Services. Diabetic Self-Management Training (DSMT) Accreditation Program [Internet]. Accessed 4 December 2019. Available from <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/DSMT-Accreditation0-Program>.
 90. Does Medicare Cover Medical Nutrition Therapy? [Internet]. Accessed 4 December 2019. Available from <https://www.medicare.com/coverage/does-medicare.com-cover-medical-nutrition-therapy/>.
 91. Cusack CM, Knudson AD, Kronstadt JL, Singer RF, Brown AL. *Practice-Based Population Health: Information Technology to Support Transformation to Proactive Primary Care.* Rockville, MD: Agency for Healthcare Research and Quality; 2010AHRQ Publication No. 10-0092-EF [Internet]. Accessed 3 September 2019. Available from <https://pcmh.ahrq.gov/sites/default/files/attachments/Information%20Technology%20to%20Support%20Transformation%20to%20Proactive%20Primary%20Care.pdf>.
 92. Siminerio L, Ruppert K, Huber K, Toledo FGS. Telemedicine for Reach, Education, Access, and Treatment

- (TREAT): linking telemedicine with diabetes self-management education to improve care in rural communities. *Diabetes Educ.* 2014;40:797-805.
93. Phillips LS, Barb D, Yong C, et al. Translating what works: a new approach to improve diabetes management. *J Diabetes Sci Technol.* 2015;9:857-864.
 94. Shea S, Weinstock RS, Teresi JA, et al; IDEATel Consortium. A randomized trial comparing telemedicine case management with usual care in older, ethnically diverse, medically underserved patients with diabetes mellitus: 5 year results of the IDEATel study. *J Am Med Inform Assoc.* 2009;16:446-456.
 95. Hunt JS, Siemenczuk J, Gillanders W, et al. The impact of a physician-directed health information technology system on diabetes outcomes in primary care: a pre- and post-implementation study. *Inform Prim Care.* 2009;17:165-174.
 96. Institute of Medicine Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century* [Internet]. Washington, DC: National Academies Press; 2001. Accessed 1 October 2019. Available from <https://www.ncbi.nlm.nih.gov/books/NBK22274/>.
 97. Fisher L, Hessler DM, Polonsky WH, Mullan J. When is diabetes distress clinically meaningful?: establishing cut points for the Diabetes Distress Scale. *Diabetes Care.* 2012;35:259-264.
 98. Association of Diabetes Care and Education Specialists. Repositioning the Specialty and Association [Internet]. Accessed 15 November 2019. Available from <https://www.diabeteseducator.org/practice/new-name-title>.
 99. NDBDE. What is a CDE? Certification Info, Diabetes Education, Certification, Examination [Internet]. Accessed 15 November 2019. Available from https://www.ncbde.org/certification_info/what-is-a-cde/.
 100. Association of Diabetes Care and Education Specialists. Board Certified-Advanced Diabetes Management (BC-ADM) [Internet]. Accessed 15 November 2019. Available from https://www.diabeteseducator.org/education/certification/bc_adm.

AUTHOR INFORMATION

M. A. Powers is with HealthPartners, Bloomington, MN. J. K. Bardsley is with the Medstar Health Research Institute, MedStar Diabetes Institute, and MedStar Health System Nursing, Hyattsville, MD. M. Cypress is an independent consultant, Albuquerque, NM. M. M. Funnell is with the University of Michigan Medical School, Ann Arbor, MI. D. Harms is with MercyOne Clive Internal Medicine, Clive, IA. A. Hess-Fischl is with the Section of Adult and Pediatric Endocrinology, Diabetes, and Metabolism, University of Chicago, Chicago, IL. B. Hooks is with Martin Army Community Hospital, Fort Benning, GA. D. Isaacs is with the Cleveland Clinic Diabetes Center, Cleveland, OH. E. D. Mandell is with Johnson & Wales University, Providence, RI. M. D. Maryniuk is with Maryniuk & Associates, Boston, MA. A. Norton is with DiabetesSisters, Chicago, IL. J. Rinker and S. Uelmen are with the Association of Diabetes Care & Education Specialists, Chicago, IL. L. M. Siminerio is with the University of Pittsburgh, Pittsburgh, PA.

Address correspondence to: Margaret A. Powers, MS, RD, CDE. E-mail: margaret.powers@parknicollet.com

STATEMENT OF POTENTIAL CONFLICT OF INTEREST

M. A. Powers reports research funding from Abbott Nutrition, is a senior advisor for ADA's Nutrition Interest Group, and is a member of ADA/ American Heart Association Science Advisory Group for Know Diabetes by Heart. J. K. Bardsley reports being a past chair of the Certification Board for Diabetes Care and Education, is the program chair for the Association of Diabetes Care & Education Specialists annual meeting, and has been a consultant to Joslin Diabetes Center. M. M. Funnell is on an advisory board of Eli Lilly. D. Harms is the treasurer for the American Academy of Nurse Practitioners Certification Board of Commissioners and Vice President of the American Nurse Practitioner Foundation. A. Hess-Fischl reports receiving an honorarium from ADA as an Education Recognition Program auditor and is a participant in a speakers bureau sponsored by Abbott Diabetes Care and Xeris. D. Isaacs reports being a participant in a speakers bureau/ consultant for Xeris Pharmaceuticals, Novo Nordisk, Dexcom, and Lifescan. M. D. Maryniuk reports being a paid consultant of Diabetes — What to Know, Arkray, and DayTwo. A. Norton reports being a participant in speakers bureaus sponsored by Boehringer Ingelheim, Novo Nordisk, and Xeris. L. M. Siminerio reports research grant funding from Becton Dickinson. S. Uelmen has received honoraria from ADA. No other potential conflicts of interest relevant to this article were reported.

FUNDING/SUPPORT

This activity was funded by the ADA and the Association of Diabetes Care & Education Specialists.

ACKNOWLEDGEMENTS

The authors would like to acknowledge Mindy Saraco (Managing Director, Scientific and Medical Affairs) from the ADA for her help with the development of the Consensus Report and related meetings and presentations, as well as the ADA Professional Practice Committee for providing valuable review and feedback. The authors also acknowledge Leslie Kolb, Chief Science and Practice Officer, Association of Diabetes Care & Education Specialists, for her review and support of the Consensus Report. The authors acknowledge the invited peer reviewers who provided comments on an earlier draft of this report: Christine Beebe (Quantumed Consulting, San Diego, CA), Anne L. Burns (American Pharmacists Association, Alexandria, VA), Amy Butts (Wheeling Hospital at the Wellsburg Clinic, Wellsburg, PA), Susan Chiarito (Mission Primary Care Clinic, Vicksburg, MS), Maria Duarte- Gardea (The University of Texas at El Paso, El Paso, TX), Joy A. Dugan (Touro University California, Vallejo, CA), Paulina N. Duker (Health Solutions Consultant, King of Prussia, PA), Lisa Hodgson (Saratoga Hospital, Saratoga Springs, NY), Wahida Karmally (Columbia University, New York, NY), Darlene Lawrence (MedStar Health, Washington, DC), Anne Norman (American Association of Nurse Practitioners, Austin, TX), Jim Owen (American Pharmacists Association, Alexandria, VA), Diane Padden (American Association of Nurse Practitioners, Austin, TX), Teresa Pearson (Innovative Health Care Designs, LLC, Minneapolis, MN), Barb Schreiner (Capella University, Pearland, TX), Eva M. Vivian (University of Wisconsin, Madison, WI), and Gretchen Youssef (MedStar Health, Washington, DC).

AUTHOR CONTRIBUTIONS

All authors were responsible for drafting the article and revising it critically for important intellectual content. All authors approved the version to be published.

Supplementary Table 1. Diabetes self-management education and support resources

A diabetes education program/service that meets quality standards*:

- ADCES
- ADA

<https://nf01.diabeteseducator.org/eweb/DynamicPage.aspx?Site=aade&WebCode=DEAPFindApprovedProgram>
https://professional.diabetes.org/erp_list_zip

Finding educators and additional team members:

- Certified Diabetes Care and Education Specialist (CDCES)
- Registered dietitian nutritionist (RD/RDN)
- ADA mental health provider directory
- Community health worker resources
- Peer support (including links to social media sites)

<https://www.ncbde.org/living-with-diabetes/findcde/>
<https://www.eatright.org/find-an-expert>
https://professional.diabetes.org/mhp_listing
<https://www.professional.diabetes.org/content-page/resources-community-health-workers-chws>
<https://www.diabeteseducator.org/peersupport>

Free or low-cost patient education resources (most also in Spanish)

- National Diabetes Education Program—patient education resources
- American Diabetes Association
 - o Diabetes Food Hub
- Learning About Diabetes (multiple languages)

<https://www.cdc.gov/diabetes/ndep/index.html>
<https://www.diabetes.org>
<https://www.diabetesfoodhub.org/>
<https://www.learningaboutdiabetes.org/>

DSMES and MNT are separate benefits from Medicare when delivered by an approved quality program and/or educator/dietitian. Referral:*

- DSMES services – ordered by MD/DO/NP/PA; up to 10 h first year, 2 h subsequent years
- MNT – ordered by MD or DO; up to 3 h in first year, 2 h in subsequent years (additional hours can be requested)
- Sample order form

<https://www.diabeteseducator.org/practice/provider-resources/make-a-referral>

Other resources for DSMES

- American Diabetes Association website for professionals
- Association of Diabetes Care and Education Specialists

<https://professional.diabetes.org/diabetes-education>
<https://www.diabeteseducator.org/docs/default-source/default-document-library/diabetes-services-order-formcb55dc36a05f68739c53ff0000b8561d.pdf?sfvrsn=0>

(continued on next page)

Supplementary Table 1. Diabetes self-management education and support resources (*continued*)

- Academy of Nutrition and Dietetics <http://www.eatrightpro.org/>,
<http://www.eatrightpro.org/-/media/eatrightpro-files/about-us/what-is-an-rdn-and-dtr/mntreferralform.pdf>,
<https://www.eatright.org/food/resources/learn-more-about-rdns/find-an-rdn-anywhere-you-need-one>
 - American Academy of Family Physicians <https://www.aafp.org/afp/topicModules/viewTopicModule.htm?topicModuleId=7>
 - American Association of PAs Diabetes Leadership Edge website <https://www.aapa.org/cme-central/national-health-priorities/diabetes-leadership-edge>
 - American Pharmacists Association <https://www.pharmacist.com/diabetes-management-sig>, https://www.pharmacist.com/education/pharmacist-patient-centered-diabetes-care?is_sso_called=1, <https://www.pharmacist.com/apha-asp-operation-diabetes>
-

DO, doctor of osteopathic medicine; MD, doctor of medicine; NP, nurse practitioner.

*DSMES and MNT are often covered by most private insurance payers.

Supplementary Table 2. Coding Table: Billing codes to maximize return on investment (ROI) in diabetes care and education. *Please consult with your billing and compliance teams before implementing billing codes as they are subject to change*

Code/Type	Description/service providers	Who can bill/other notes	Increments/Frequency/Limits
G0108	Diabetes outpatient self-management training services, individual	ADCES Accredited or ADA Recognized ONLY and varies by provider type.	per 30 minutes (do not round up)
G0109	Diabetes outpatient self-management training services, group session (2 or more)	ADCES Accredited or ADA Recognized ONLY and varies by provider type.	per 30 minutes (do not round up); FQHC's and RHC's excluded.
G0108 or G0109 with POS 02 modifier for Medicare; 95 modifier is often used for private payers, but may vary.	By reporting place of service (POS) 02 modifier with HCPCS code G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes) or G0109 (Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes), the distant site practitioner attests that the beneficiary has received or will receive 1 hour of in-person DSMT services for purposes of injection training when it is indicated during the year	ADCES Accredited or ADA Recognized ONLY and billed under program NPI# (same as in person visits)	per 30 minutes (do not round up) Medicare telehealth services, including individual and group DSMT services furnished as a telehealth service, could only be furnished by a physician, PA, NP, CNS, CNM, clinical psychologist, clinical social worker, or registered dietitian or nutrition professional, as applicable. RNs, Pharmacists and other instructors are excluded.
97802	MNT; initial assessment and intervention, individual, face-to-face with the patient	RD/RDN ONLY	each 15 minutes
97803	MNT; re-assessment and intervention, individual, face-to-face with the patient	RD/RDN ONLY	each 15 minutes
97804	MNT; group (2 or more individual(s))	RD/RDN ONLY	each 30 minutes
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient	RD/RDN ONLY	each 15 minutes
G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals)	RD/RDN ONLY	each 30 minutes

(continued on next page)

Supplementary Table 2. Coding Table: Billing codes to maximize return on investment (ROI) in diabetes care and education. *Please consult with your billing and compliance teams before implementing billing codes as they are subject to change (continued)*

Code/Type	Description/service providers	Who can bill/other notes	Increments/Frequency/Limits
99091	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, qualified by education, training, licensure/regulation (when applicable)	cannot be reported in conjunction with CPT® codes 95249, 95250 and/or 95251.	requiring a minimum of 30 minutes of time.
95249	Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording.	For Medicare - An MA, RN, LPN, or CDE may perform the elements in CPT codes 95249/95250 if "incident to guidelines" are met, meaning they are providing the service directed by a physician or other qualified healthcare provider.	sensor for a minimum of 72 hours; printout of recording; may not be reported more than once for the duration that the patient owns the data receiver. Obtaining a new sensor and/or transmitter without a change in the receiver does not warrant reporting 95249 subsequent times.
95250	Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording.	For Medicare - An MA, RN, LPN, or CDE may perform the elements in CPT codes 95249/95250 if "incident to guidelines" are met, meaning they are providing the service directed by a physician or other qualified healthcare provider.	sensor for a minimum of 72 hours; once per month.
95251	Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report.	MD, DO, NP, PA.	once per month
98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family); individual patient	MEDICARE WILL NOT REIMBURSE: Other payers often do.	each 30 minutes

(continued on next page)

Supplementary Table 2. Coding Table: Billing codes to maximize return on investment (ROI) in diabetes care and education. *Please consult with your billing and compliance teams before implementing billing codes as they are subject to change (continued)*

Code/Type	Description/service providers	Who can bill/other notes	Increments/Frequency/Limits
98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family); 2-4 patients	MEDICARE WILL NOT REIMBURSE: Other payers often do.	each 30 minutes
98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family); 5-8 patients	MEDICARE WILL NOT REIMBURSE: Other payers often do.	each 30 minutes
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.	Physicians can report 99211, but it is intended to report services rendered by other individuals in the practice, such as a nurse or other staff member. Unlike other office visit E/M codes, a 99211-office visit does not have any specific key-component documentation requirements.	5 minutes
G0466	Federally qualified health center (FQHC) visit, new patient; a medically-necessary, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit	FQHC	one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem

(continued on next page)

Supplementary Table 2. Coding Table: Billing codes to maximize return on investment (ROI) in diabetes care and education. *Please consult with your billing and compliance teams before implementing billing codes as they are subject to change (continued)*

Code/Type	Description/service providers	Who can bill/other notes	Increments/Frequency/Limits
G0467	Federally qualified health center (FQHC) visit, established patient; a medically-necessary, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit	FQHC	one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem
99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: <ul style="list-style-type: none"> • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; • Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; • Comprehensive care plan established, implemented, revised, or monitored. 	The CCM codes describing clinical staff activities (CPT 99487, 99489, and 99490) are assigned general supervision under the Medicare PFS. General supervision means when the service is not personally performed by the billing practitioner, it is performed under his or her overall direction and control although his or her physical presence is not required.	at least 20 minutes; once per month

(continued on next page)

Supplementary Table 2. Coding Table: Billing codes to maximize return on investment (ROI) in diabetes care and education. *Please consult with your billing and compliance teams before implementing billing codes as they are subject to change (continued)*

Code/Type	Description/service providers	Who can bill/other notes	Increments/Frequency/Limits
99491	<p>Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements:</p> <ul style="list-style-type: none"> • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient • Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline • Comprehensive care plan established, implemented, revised, or monitored 	<p>Physicians and the following non-physician practitioners may bill CCM services:</p> <ul style="list-style-type: none"> • Certified Nurse Midwives Clinical Nurse Specialists • Nurse Practitioners • PAs 	at least 30 minutes, once per month
99487	<p>Complex chronic care management services, with the following required elements:</p> <ul style="list-style-type: none"> • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline • Establishment or substantial revision of a comprehensive care plan • Moderate or high complexity medical decision making • 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month 	<p>The CCM codes describing clinical staff activities (CPT 99487, 99489, and 99490) are assigned general supervision under the Medicare PFS. General supervision means when the service is not personally performed by the billing practitioner, it is performed under his or her overall direction and control although his or her physical presence is not required.</p>	60 minutes, once per month

(continued on next page)

Supplementary Table 2. Coding Table: Billing codes to maximize return on investment (ROI) in diabetes care and education. *Please consult with your billing and compliance teams before implementing billing codes as they are subject to change (continued)*

Code/Type	Description/service providers	Who can bill/other notes	Increments/Frequency/Limits
99489	<p>Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure).</p> <p>Complex CCM services of less than 60 minutes in duration, in a calendar month, are not reported separately. Report 99489 in conjunction with 99487. Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month.</p>	<p>Time spent directly by the billing practitioner or clinical staff counts toward the threshold clinical staff time required to be spent during a given month. CCM services that are not provided personally by the billing practitioner are provided by clinical staff under the direction of the billing practitioner on an "incident to" basis (as an integral part of services provided by the billing practitioner), subject to applicable state law, licensure, and scope of practice. The clinical staff are either employees or working under contract to the billing practitioner whom Medicare directly pays for CCM.</p>	<p>Additional 30 minutes, once per month; Complex CCM services of less than 60 minutes in duration, in a calendar month, are not reported separately. Report 99489 in conjunction with 99487. Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month.</p>
99457	<p>Remote physiologic monitoring treatment management services requiring interactive communication with the patient/caregiver during the month</p>	<p>Clinical staff/physician/other qualified healthcare professional time</p>	<p>20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month</p>
99605	<p>Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, initial 15 minutes, with assessment, and intervention if provided</p>	<p>Pharmacist</p>	<p>initial 15 minutes, new patient</p>

(continued on next page)

Supplementary Table 2. Coding Table: Billing codes to maximize return on investment (ROI) in diabetes care and education. *Please consult with your billing and compliance teams before implementing billing codes as they are subject to change (continued)*

Code/Type	Description/service providers	Who can bill/other notes	Increments/Frequency/Limits
99606	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, initial 15 minutes, established patient	Pharmacist	initial 15 minutes, established patient
99607	Medication therapy management services provided by a pharmacist, individual, face-to-face with patient, each additional 15 minutes (List separately in addition to code for the primary service)	Pharmacist	each additional 15 minutes (Use 99607 in conjunction with 99605, 99606)

MDPP: Medicare Diabetes Prevention Program utilizes a number of codes that are further clarified at the following link: <https://innovation.cms.gov/Files/x/mdpp-billingpayment-refguide.pdf>

References

- Use Medicare's [Physician Fee Schedule Look-up Tool](#) to Search Medicare's database by CPT® code and Medicare Administrative Contractor (MAC)
- [Contact](#) your MAC for specific coverage and billing guidelines and requirements.
- Refer to the most recent edition of the [CPT® code book](#) for current CPT® code information.
- [Medicare Reimbursement Guidelines for DSMT](#)
- [AAFP Guide to 99211](#)
- [AACE Guide to CGM Codes](#)