

**Diabetes Self-Management Training (DSMT)
INFORMATION RESOURCE**

TABLE OF CONTENTS

LIST OF TABLES iii

PURPOSE 1

DEFINITIONS 1

OPPORTUNITY FOR CBOS TO OFFER DSMT 2

NATIONAL ACCREDITATION/RECOGNITION OVERVIEW 2

National Standards 2

National Accrediting Organizations 3

AADE Accreditation 3

ADA Recognition 3

Accreditation Requirements 4

Annual Reports and Renewals 5

MEDICARE REQUIREMENTS FOR DSMT 5

Clinical Supervision Requirements 5

Staffing 6

Hours of Training Covered 6

Billing 7

Deductible, Coinsurance, and Medigap Policies 7

Medicare Advantage Coverage 7

Coverage by Other Health Plans 8

3-STEP PATH TO ATTAIN MEDICARE REIMBURSEMENT FOR DSMT 8

MEDICAL NUTRITION THERAPY 8

Clinical Supervision 9

Physician Order 9

Hours of Service and Billing for MNT 9

Deductible and Coinsurance for MNT 10

Medicare Advantage and MNT	10
Benefits of Offering DSMT and MNT Together.....	10
DSMP AS THE CURRICULUM FOR A DSMES/DSMT PROGRAM.....	11
The 10 National Standards and Application to DSMP as the Curriculum for a DSMES Program	11
Standard 1. Internal Structure	12
Standard 2. Stakeholder Input	12
Standard 3. Evaluation of Population Served.....	13
Standard 4. Quality Coordinator Overseeing DSMES Services	13
Standard 5. DSMES Team	14
Standard 6. Curriculum.....	15
Standard 7. Individualization	17
Standard 8. Ongoing Support.....	18
Standard 9. Participant Progress	19
Standard 10. Quality Improvement	20
Sample Policy and Procedure Manual	21
PLANNING AND IMPLEMENTING THE DSMP TEST CLASS	21
DOCUMENTATION FLOW AND SAMPLE FORMS	22
Initial Assessment and Individualized Education Plan	22
Group Interventions/Weekly Action Plan.....	22
DSMES Individual Interventions/Progress Notes	23
Ongoing Diabetes Self-Management Support Plan	23
DSMES Follow-Up Plan	23
PUTTING THE PIECES TOGETHER: PRACTICAL STEPS AND STRATEGIES FOR IMPLEMENTING AND SUSTAINING A SUCCESSFUL DSMT SERVICES PROGRAM.....	23
KEY STEPS TO DEVELOP AND IMPLEMENT A MEDICARE RECOGNIZED DSMT SERVICES PROGRAM.....	24
FIVE PROVEN STRATEGIES TO DEVELOP A SUSTAINABLE BUSINESS MODEL.....	25

LIST OF TABLES

Table 1: CPT Codes, Service, Units, and Rates for DSMT	7
Table 2: CPT Codes, Service, Units, and Rates for MNT	10
Table 3. Topics to be Covered in the DSMES Curriculum and Which Session They Are Addressed in DSMP	16

Purpose

The purpose of this resource is to provide valuable information to help community-based organizations (CBOs) plan, implement, and sustain an accredited diabetes self-management education and support (DSMES) program based on Medicare reimbursement for the Diabetes-Self-Management Training (DSMT) benefit. The intended audience is the diverse network of CBOs across the United States focused on aging and disability services, including area agencies on aging, other aging and disability services providers, public health departments, and tribal entities.

Definitions

Diabetes Self-Management Education and Support (DSMES) Services - This is the term used in the 2017 National Standards for DSMES to refer to the ongoing process involved in supporting individuals with diabetes to increase their knowledge, skills, and ability for self-care. It includes behaviors and activities to manage diabetes on an ongoing basis over time, beyond the scope of formal training and education.

Diabetes Self-Management Program (DSMP) - This is the term used for the six-week group self-management education program originally developed at Stanford University to help people with diabetes learn strategies, build skills, and set goals to manage their health. This and other self-management education programs originally developed at Stanford are now managed by the [Self-Management Resource Center \(SMRC\)](#).

Diabetes Self-Management Training (DSMT) - This is the term defined in the Balanced Budget Act of 1997 and used by the Centers for Medicare & Medicaid Services (CMS) to describe “educational and training services furnished . . . to an individual with diabetes by a certified provider . . . in an outpatient setting.” The services are offered “to ensure therapy compliance or to provide the individual with necessary skills and knowledge” to manage diabetes. DSMT programs must meet the National Standards for Diabetes Self-Management Education and Support (DSMES) and be accredited by a national accrediting organization approved by CMS.

Accreditation/Recognition - The accreditation/recognition process helps ensure that DSMES provision consists of quality education that adheres to the 10 National Standards for DSMES. The American Association of Diabetes Educators (AADE) uses the term accreditation for their process, while the American Diabetes Association (ADA) uses the term recognition.

Diabetes Education Accreditation Program (DEAP) - This term refers to a diabetes self-management education and support (DSMES) program that has been accredited by the American Association of Diabetes Educators (AADE).

Education Recognition Program (ERP) - This term refers to a DSMES program that has been recognized by the American Diabetes Association (ADA).

Opportunity for CBOs to Offer DSMT

Diabetes is a serious chronic health condition affecting 12% of adults and 25% of those 65 years of age or older in the United States. It can cause long-term health complications, including impaired vision, heart disease, stroke, kidney failure, and amputations, which are associated with disability and premature death. Diabetes is the seventh leading cause of death in the nation and places a tremendous burden on individuals, their families, and the health and social welfare system. The annual cost of diabetes in the United States is estimated at \$245 billion, and medical expenditures for people with diabetes are 2.3 times more than for those without diabetes. (CDC 2017 National Diabetes Statistics Report)

Fortunately, quality and timely DSMES services can help people with diabetes learn to manage their condition, prevent complications, and improve their overall health and wellbeing. Further, the provision of DSMES services benefits the health care system by improving population health outcomes and reducing health care costs. While DSMES services have been proven effective in improving health outcomes, lowering the risk for complications, and reducing hospital admissions and readmissions, few Medicare beneficiaries receive the DSMT benefit.

CBOs focused on aging and disability services can play an integral role in expanding the use of the Medicare DSMT benefit among older adults with a diagnosis of diabetes. Typically, they provide vital health and nutrition services to help older adults age with dignity in their communities. Many older adults who are already being served by CBOs could benefit from participating in DSMT classes, especially those who experience health inequities due to race/ethnicity or social determinants of health, such as income, education, housing, social supports, geographic location, and language/literacy.

CBOs are experienced in addressing cultural and social factors that drive health care outcomes, while health care systems may be ill equipped to handle these issues. Therefore, CBOs are well positioned to partner with health care providers and payers to help improve health outcomes and lower costs for their patients or members by offering the DSMT benefit. As value-based payment models, which reward providers for quality of care, become more widespread, CBOs have a ripe opportunity to demonstrate the benefits of DSMT services.

National Accreditation/Recognition Overview

National Standards. The 10 National Standards for DSMES define quality, evidence-based services to operate a DSMES program and are used for national accreditation/recognition. CBOs that intend to bill Medicare for DSMT services are required to meet these standards and attain national accreditation/recognition by a CMS-approved accrediting organization. The Standards are revised every five years, and the 2017 National Standards for DSMES are the most recent version. See pages 12-22 for a listing of each standard and a discussion of how to meet the requirements when DSMP is used as the curriculum.

National Accrediting Organizations. There are two CMS-approved national accrediting organizations, the American Association of Diabetes Educators (AADE) and the American Diabetes Association (ADA). Although there are some individual differences, both organizations endorse and use the National Standards for DSMES to guide the accreditation/recognition process. AADE uses the term accreditation, while ADA uses the term recognition.

A CBO that intends to become accredited should review the requirements for each accrediting organization and choose whether to apply through AADE or ADA. An extensive application must be submitted, along with an application fee for a four-year cycle. The process may be completed online. Establishing an accredited DSMES program is necessary to become a Medicare provider of DSMT services.

AADE Accreditation. The average approval time for accreditation is from four to six weeks. Community sites, which are an extension of the main site, are free. There is an additional fee for each branch site, which operates semi-independently from the main site.

Helpful Links When Applying for AADE Accreditation

AADE has an abundance of information and resources on their website to help organizations prepare for and complete the accreditation application. A few key links are listed below.

- Applying for AADE Accreditation, Step-by-Step Process:
[https://www.diabeteseducator.org/practice/diabetes-education-accreditation-program-\(deap\)/ready-to-apply-to-deap](https://www.diabeteseducator.org/practice/diabetes-education-accreditation-program-(deap)/ready-to-apply-to-deap)
- Chart Explaining the Difference in Community Sites and Branch Sites:
[https://www.diabeteseducator.org/practice/diabetes-education-accreditation-program-\(deap\)/additional-sites](https://www.diabeteseducator.org/practice/diabetes-education-accreditation-program-(deap)/additional-sites)
- AADE Interpretative Guidance for the 2017 National Standards:
https://www.diabeteseducator.org/docs/default-source/practice/deap/standards/2017-interpretive-guidance-nov-rev_final.pdf?sfvrsn=6

ADA Recognition. Applications for ADA recognition are generally processed in under 30 days. Each program has one primary multi-site. A program may add additional sites at any time. There is no additional fee for expansion sites that extend from the primary or other multi-site. However, there is a fee, above the baseline fee, for each additional multi-site.

Helpful Links When Applying for ADA Recognition

ADA's website contains a great deal of information and resources to help organizations prepare for and complete the ADA recognition process. A few key links are listed below.

- Applying for and Maintaining ADA Recognition:
<https://professional.diabetes.org/diabetes-education>
- Recognition Requirements:
<https://professional.diabetes.org/sites/professional.diabetes.org/files/media/erp-10th-edition-recognition-requirements.pdf>
- Benefits of ADA Recognition:
<https://professional.diabetes.org/sites/professional.diabetes.org/files/media/erp-10th-edition-recognition-requirements.pdf>

Accreditation Requirements

There are specific requirements for the initial accreditation, including compliance with the 10 National Standards for DSMES, supporting documentation about the program, and submission of select patient records to demonstrate compliance with the Standards. The application must include the following components:

- DSMES Policy and procedure manual that demonstrates compliance with the Standards.
- A list of stakeholders who will provide input and advice regarding delivery, monitoring, and evaluation of the program and minutes to any meetings if the stakeholder group has been convened.
- Organizational chart.
- Position descriptions for all personnel participating in delivery of the program.
- Qualifications and training (15 hours of continuing education) for personnel. (See Standards 4 and 5, pages 13-15).
- A formal continuous quality improvement (CQI) process, including baseline data for at least one clinical (outcome) measure and one qualitative (process) measure that the program will track annually (see Standard 10, pages 20-21).
- The program curriculum that has been selected (e.g., DSMP), its evidence, and the content covered in each session.
- Completion of a "test class" with documentation that one or more de-identified participants went through the DSMES program curriculum within 6 months prior to the application date. It is recommended to enclose three separate de-identified health records with the application to ensure that at least one meets the guidelines. See pages 21-22 for more information about planning for and implementing the test class when DSMP is used as the curriculum.

Once the application is received and reviewed by AADE or ADA, a telephone or in-person interview will be scheduled with the applicant to complete the accreditation/recognition

process. The applicant will be asked questions and expected to provide verbal confirmation about how their program delivery process meets the National Standards.

After the ADA/AADE accreditation determination is made, the applicant has one week to notify the accrediting organization of any changes that need to be made to the official name of the program. If changes are needed, an additional fee may be incurred. Depending on the outcome of the accreditation recognition review, the accrediting organization can issue an accreditation for up to 4 years.

Annual Reports and Renewals. DEAPs/ERPs are subject to audit, and an annual status report must be submitted each year during the accreditation/recognition cycle to maintain DEAP/ERP status. After the completion of the accreditation term, a renewal application and fee are required to continue to operate the program.

Medicare Requirements for DSMT

Section 4105 of the Balanced Budget Act of 1997 permits Medicare coverage of DSMT “when these services are furnished by a certified provider who meets certain quality standards.” In 2002, Medicare began offering the DSMT as a covered Part B benefit.

In order to receive DSMT services, a Medicare beneficiary must have a diagnosis of diabetes. A written order from the physician or non-physician practitioner (e.g., nurse practitioner or physician assistant) is required to verify the diagnosis and certify the need for DSMT before services are initiated. For Medicare coverage, the order must be filed in the health record, and the record must contain documentation confirming that the beneficiary has diabetes. Medicare uses the following list of guidelines to define diabetes:

- A fasting blood sugar greater than or equal to 126 mg/dl on two different occasions
- A two-hour post glucose challenge greater than or equal to 200 mg/dl on two different occasions
- Random glucose test over 200 mg/dl for a person with symptoms of uncontrolled diabetes

AADE and the Academy of Nutrition and Dietetics developed an [Order Form](#) to assist the physician or other qualified provider when making a referral. The form has fields to address all of the required information.

Clinical Supervision Requirements. The National Standards for DSMES allow for a registered nurse (RN), registered dietitian (RD), pharmacist with training and experience pertinent to DSMES, or another health professional with certification as a diabetes educator (CDE) or Board Certification in Advanced Diabetes Management (BC-ADM) to serve as the qualified clinician (see Standard 5, pages 14-15).

Although the National Standards allow for a range of licensed providers, Medicare has specific requirements on the types of clinicians that can operate as independent providers in the

Medicare program. A registered dietitian is eligible to become an independent provider of Medicare Part B services. However, registered nurses, registered pharmacists, or other qualified health professionals are not eligible to become independent providers of Medicare Part B services. One exception to this requirement occurs when DSMT services are provided by a pharmacy. A pharmacist, operating in an approved Part B pharmacy, can provide DSMT services and bill those services under the National Provider Identifier (NPI) of the pharmacy. Therefore, a CBO could opt to partner with a local pharmacy to meet the Medicare Part B supervision requirements.

During the delivery of DSMES services, the licensed clinician must provide a face-to-face DSMES assessment and complete an individualized education plan for each participant in collaboration with the participant and the clinical team. The RD is required to supervise the lay leader group-led sessions and must be available during each session.

Staffing. Medicare requires DSMT services to be delivered by a nationally accredited program. Therefore, in order to be reimbursed by Medicare, a CBO must meet the staffing requirements described in the National Standards. The Standards describe an interprofessional team approach to providing services in coordination with the referring provider.

The team should consist of a licensed clinician (see *Clinical Supervision Requirements* above) and a quality coordinator overseeing DSMES. The licensed clinician is responsible for completing the assessment and individualized education plan and for providing supervision of DSMES interventions offered by other team members. The role of the quality coordinator is to oversee the delivery, monitoring, and evaluation of DSMES; to implement a CQI process; and to ensure all Standards are met. The roles of the licensed clinician and the quality coordinator can be assigned to two different persons, or the licensed clinician can serve in a dual role (generally for a small program). Other health workers and paraprofessionals (e.g., lay leaders, health coaches) who have appropriate training and supervision can also serve as members of the team.

The CBO is responsible for ensuring that all DSMES team members are qualified and competent to provide quality DSMES/DSMT services. Additionally, appropriate continuing education for all team members must be documented (see Standards 4 and 5, pages 13-15).

Hours of Training Covered. During the first year (12 months from the initiation of DSMT services), Medicare has a 10-hour benefit limit for DSMT: one hour of individual training and nine hours of group training. After the first year, there is a lifetime benefit of up to two hours of follow-up training each year. The training is billed in 30-minute increments.

Medicare regulations allow a group to include as few as two participants and as many as 20. However, DSMP has fidelity requirements about the number of participants, and the program licensed to deliver DSMP is responsible for ensuring program fidelity. Groups can be comprised of Medicare Part B beneficiaries, as well as individuals who do not have Medicare Part B coverage.

Billing. See Table 1 below for the CPT codes, units, and rates used to bill individual and group DSMT services.

Table 1: CPT Codes, Service, Units, and Rates for DSMT

CPT[®] Code	Service	Allowable Units Annually (1 unit = 30 minutes)	Rate* Per Unit (2019)
GOI08	DSMT Individual	2 units (1 hour)	\$56.22
GO109	DSMT Group	18 units (9 hours)	\$15.50

*Rates shown here are an average of rates for 2019. Rates change each calendar year and are subject to change based on the Metropolitan Statistical Area (MSA) variation. Specific rates can be found by referencing the requisite Medicare Administrative Contractor (MAC).

Deductible, Coinsurance, and Medigap Policies. Medicare Part B requires an annual deductible for all beneficiaries. The deductible must be met before Medicare will provide reimbursement for DSMT services. Once the deductible is met, there is a 20% coinsurance for most Medicare Part B services, including DSMT. Fee-for-service Medicare pays 80% of the fee schedule rate, and the beneficiary is responsible for the remaining 20%.

Many Medicare beneficiaries have additional health insurance coverage through a Medigap policy or state Medicaid that pays the annual deductible and coinsurance not covered by Medicare. A Medigap policy is a health plan sold by private insurance companies to fill the “gaps” in Original Medicare coverage. Medicare beneficiaries who also have Medicaid coverage are known as “dual eligibles” or “duals.” Medicaid is mandated to cover the remaining Part B coinsurance for duals, i.e., 20% of the approved amount for the DSMT services rendered.

CBOs are expected to bill the beneficiary, the appropriate Medigap policy, or the state Medicaid plan for the coinsurance. They should collect proof of identification and verify ALL coverage information (i.e., Medicare, Medigap, and Medicaid) for each person who will receive DSMT prior to delivering the services. Information submitted on claims, including the way the name is listed, must be identical to the way it appears on the insurance card(s). By developing a quality billing process, CBOs can prevent underpayment or delays in payment due to unnecessary errors, such a wrong insurance number or a misspelled name, which could potentially jeopardize the program’s financial sustainability.

Medicare Advantage Coverage. Medicare Advantage (MA) plans are required to cover all Part A and B services. Therefore, all beneficiaries enrolled in an MA plan have DSMT coverage, and those who meet the medical necessity requirements for DSMT are eligible to receive the services as a covered benefit.

A special contract is not required to provide DSMT services to MA plan members. However, some plans require prior authorization for DSMT services to be provided. Therefore, CBOs

interested in delivering DSMT services to MA plan members should contact the plan to inquire about the process to enroll as a network provider.

Coverage by Other Health Plans. In addition to Original Medicare, a number of other insurance plans also cover DSMT. Prior to offering DSMT to a health insurance plan's members, it is important to notify the plan of the intention to provide the services, enroll as a provider, and inquire about whether there are prior-authorization requirements. Generally, rates for DSMT covered by commercial insurance carriers can be negotiated with each plan.

3-Step Path to Attain Medicare Reimbursement for DSMT

Essentially, there are three key steps to develop a DSMES program that meets the Medicare requirements for DSMT reimbursement.

Step 1 - Attain national accreditation/recognition from AADE or ADA.

Step 2 - Enroll as a Medicare provider or partner with a Medicare provider. DSMT cannot be the primary service. Medical Nutrition Therapy (MNT), which can be offered in conjunction with DSMT, can serve as the primary service. (See pages 9-11 for more information about MNT.)

Becoming a Medicare provider is a two-part process that involves obtaining a Provider Transaction Access Number (PTAN) and a National Provider Identifier (NPI). To help CBOs understand more about becoming a Medicare provider, NCOA and n4a developed the following resource: Understanding the Benefits, Opportunities, Responsibilities, and Risks Associated with Becoming a Medicare Provider: What Community-Based Organizations Need to Know.

Step 3 - Attain Medicare recognition of the DEAP/ERP by submitting a copy of the accreditation or recognition certificate to the designated Medicare Administrative Contractor (MAC). MACs are private health plans awarded contracts by CMS to serve as the primary operational contact between the Medicare fee-for-service program and health care providers enrolled in the program for the designated area (multi-state or regional). Among other duties, MACs are responsible for enrolling fee-for-service providers in Medicare and administering Part A and Part B claims for Medicare beneficiaries on behalf of CMS. CBOs can find the designated MAC for their area at the following link: <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs.html>.

The name of the legal entity enrolled as the Medicare provider must be on the certificate that is submitted to the MAC, and the provider's PTAN must be active. The CBO should maintain a receipt verifying that the certificate was sent and may also want to call the MAC to confirm receipt of the certificate.

Medical Nutrition Therapy

Medical nutrition therapy (MNT) services can be offered in conjunction with DSMT. Section 1861(s)(2)(V) of the Social Security Act authorizes Medicare Part B coverage of MNT. The coverage requirements were established in the Code of Federal Regulations at 42 CFR §§410.130 – 410.134 effective January 1, 2002 for beneficiaries with one or more of the following conditions:

- Diabetes
- Kidney disease
- A kidney transplant within 36 months prior to service

The following services are covered:

- Nutritional and lifestyle assessment and individualized care plan
- Individual nutritional therapy counseling and education
- Group nutritional therapy counseling and education (two or more individuals)
- Follow-up visits to check on progress in managing a diet

Clinical Supervision. The services must be provided by or under the direct supervision of a registered dietitian or other qualified nutrition professional who meets certain requirements. To deliver MNT services under Original Medicare, the qualified clinician must be enrolled in Medicare.

Physician Order. As with DSMT, the physician must verify the diagnosis and write an order for the type of MNT services and the number of hours that are medically necessary. While the Medicare requirements allow physicians and other qualified practitioners (i.e., physician assistants or nurse practitioners) to order DSMT services, only a physician can order MNT. The [Order Form](#) for DSMT is also designed to be used for MNT.

Hours of Service and Billing for MNT. During the first year (twelve months following the initiation of services), three hours of MNT can be provided. After an initial individual assessment, interventions can be provided individually or in a group setting, based on the clinician's discretion. During subsequent years, two hours of services can be provided as long as the beneficiary continues to meet the diagnosis and medical necessity criteria. See Table 2 below for CPT code information and rates.

Table 2: CPT Codes, Service, Units, and Rates for MNT

CPT ® Code*	Service	Allowable Units Annually**	Rate* Per Unit (2019)
97802	MNT individual, initial assessment and intervention	1 hour (4 units / 15 minutes each)	\$37.84
97803	MNT individual reassessment and intervention	2 hours (4 units / 30 minutes each)	\$32.80
97804	MNT group (2 or more individuals)	2 hours (4 units / 30 minute increments)	\$17.30

*Rates shown here are an average of rates for 2019. Rates change each calendar year and are subject to change based on the Metropolitan Statistical Area (MSA) variation. Specific rates can be found by referencing the requisite Medicare Administrative Contractor (MAC).

**Three hours is the maximum billable time during the initial 12 months of service.

Deductible and Coinsurance for MNT. There is no deductible or coinsurance for MNT.

Medicare Advantage and MNT. Because MNT is a Medicare Part B benefit, all MA plans are required to cover the services.

Benefits of Offering DSMT and MNT Together. Individuals with diabetes can benefit from both MNT and DSMT; each service provides specific benefits. Offering the services together can be an effective means of helping Medicare beneficiaries with diabetes understand and follow an individualized nutrition plan with adequate calories and nutrient needs, regulate blood glucose levels, learn strategies for managing their diabetes, and increase self-care behaviors. Note: While DSMT and MNT can be provided to the same beneficiary during the same 12 month period, both services cannot be provided to the same beneficiary on the same date of service.

In addition to benefits for the Medicare beneficiary, there are benefits for the CBO that offers both services. Foremost, the CBO can use MNT as the primary service to enroll with Medicare as a DSMT provider. Moreover, by offering both services, rather than a single service, a CBO is better positioned to address the clinical needs of individuals with diabetes and to market their services to health care providers and plans whose patients and members can benefit from this complementary approach to diabetes care. Further, delivering both services together creates additional revenue to help cover the costs associated with offering the 16-hour DSMP curriculum and the clinical wrap-around structure to sustain the DSMES/DSMT program. For more information on the MNT benefit, please refer to NCOA's [MNT Tip Sheet](#).

MNT can be provided individually or in a group setting and requires a written order from a physician prior to the initiation of therapy. Under certain special circumstances, a physician can

order additional MNT beyond the initial three (3) hour benefit. However, the additional hours must be first approved by the MAC and will require clinical documentation to justify the need for additional services. If approved, the beneficiary can receive up to three hours of additional benefit. Some of the reasons that additional education can be authorized include a change in the diagnosis, medical condition, or treatment regimen.

DSMP as the Curriculum for a DSMES Program

The Diabetes Self-Management Program (DSMP), originally developed at Stanford University, can be used as the curriculum for a DSMES/DSMT program. However, to meet the National Standards and fulfill the requirements for accreditation, specific wraparound elements must be added to the existing DSMP structure. When adding these elements, the CBO must ensure adherence to the licensing requirements for DSMP and fidelity to the original evidence-based program design.

The six-week DSMP class is the primary intervention offered as a component of an individualized DSMES services plan based on the initial assessment developed collaboratively with the participant, referring provider, and DSMES team. The class sessions are delivered by two trained group (lay) leaders under the supervision of a qualified licensed clinician. Individual and/or group MNT can also be offered, in conjunction with the DSMT benefit.

Six Additional Elements Necessary for DSMP to Meet Accreditation Requirements

1. A planned strategy for ongoing input from stakeholders and experts to promote quality and enhance participant utilization of the services.
2. A CQI plan.
3. An assessment and individualized DSMES plan developed collaboratively with the participant, referring provider, and DSMES team prior to offering the DSMP class.
4. A licensed clinician on site during each group session to provide clinical supervision.
5. At the conclusion of formal, billable DSMES services, options and resources made available for ongoing support to maintain the participant's self-management goals.
6. A follow-up plan developed collaboratively with each participant and the DSMES team to communicate progress, goals achieved, and recommendations for ongoing care to the referring provider.

The 10 National Standards and Application to DSMP as the Curriculum for a DSMES Program

This section provides a listing of the 10 National Standards and a description of each standard, including how it applies to use of DSMP as the curriculum for the DSMES program. For each standard, there is also a checklist of documentation requirements to help CBOs prepare their accreditation application.

Standard 1. Internal Structure

The provider(s) of DSMES services will define and document a mission statement and goals. The DSMES services are incorporated within the organization—large, small, or independently operated.

This standard requires the CBO to demonstrate how DSMES services are incorporated into its overall mission and goals. An organizational structure should be in place to provide leadership, support, and an effective communication flow to ensure appropriate delivery of the services, outcome measurement, and a systematic quality improvement process.

Required documentation checklist to meet Standard 1:

- Mission statement describing the purpose of the DSMES program
- Program goals that link back to the mission statement
- Organizational chart depicting DSMES positions and reporting relationships
- Letter of support from leadership, e.g., CEO, President, Director, Clinical Manager, Quality Manager, Owner, Supervisor, etc.

Standard 2. Stakeholder Input

The provider(s) of DSMES services will seek ongoing input from valued stakeholders and experts to promote quality and enhance participant utilization.

The CBO is required to document a planned strategy for how stakeholders and experts will be engaged. The purpose of stakeholder input is to work toward improving outcome measures, as well as the utilization, quality, and sustainability of DSMES services. While a formal advisory board is not required, key stakeholders and experts are expected to provide ongoing input (by phone, in person, or email) at least annually.

Stakeholders can be identified from participants, community members, referring providers, and lay leaders. Key partners or potential partners, such as local health departments, health care professionals, and health care entities may also offer valuable input. The quality coordinator overseeing DSMES and the qualified clinician(s) should be involved, and other internal staff may also be included.

Required documentation checklist to meet Standard 2:

- A list of stakeholders
- Minutes to the stakeholder meeting if one has been held prior to submitting the accreditation application
- The planned strategy for engaging the stakeholders at least annually, including how often they will meet, how they will meet (i.e., in person, by phone, video conferencing, or email), and their functions, including review and recommendations regarding DSMES utilization, program planning and evaluation, the CQI process, and outcome measures.

Standard 3. Evaluation of Population Served

The provider(s) of DSMES services will evaluate the communities they serve to determine the resources, design, and delivery methods that will align with the population's need for DSMES services.

To provide quality services for people with diabetes, it is important for the CBO to conduct a needs assessment to understand the region and community that will be served, including the population demographics, prevalence and impact of diabetes, perception of risk, and population subgroups more likely to be affected or experience the complications associated with diabetes. Barriers to accessing and utilizing DSMES services should be identified and creative solutions sought to address the needs of the target population. Individual barriers may include lack of understanding about the benefits of DSMES, inadequate health insurance coverage, cultural factors, low health literacy, or lack of transportation. Other barriers may include lack of support for DSMES from providers, a limited number of programs to address the burden, gaps in services in specific geographic areas or communities, or poor cultural tailoring of programs for the target population.

Creative solutions to overcome barriers that have been identified should be developed.

Strategies to address barriers include the following:

- Provide or arrange for transportation to DSMES classes
- Hold classes in accessible settings
- Establish a user-friendly enrollment process
- Develop marketing materials and educational resources that are culturally appropriate and at the appropriate level of health literacy
- Build referral relationships with providers and other partners to increase the program reach
- Forge partnerships to help increase the program reach
- Explore the use of telehealth and technology to increase engagement and the program reach

Required documentation checklist to meet Standard 3:

- A needs assessment, including demographics of the community served
- Identification of barriers to DSMES services
- Creative solutions to address barriers to services and delivery methods that align with the population's needs, including accessible settings, adaptations for low vision or blind populations, interpreter services, and other accommodations that may be needed

Standard 4. Quality Coordinator Overseeing DSMES Services

A quality coordinator will be designated to ensure implementation of the Standards and oversee the DSMES services. The quality coordinator is responsible for all components of DSMES,

including evidence-based practice, service design, evaluation, and continuous quality improvement.

The requirement for a quality coordinator overseeing DSMES services is new to the 2017 National Standards and reflects a heightened focus on continuous quality improvement and evaluation to improve program processes and participant outcomes as essential elements of sustainable DSMES services. Previous versions of the Standards used the term program coordinator.

The quality coordinator's role is to ensure quality throughout the provision of DSMES services, gather data to analyze gaps in services, and provide feedback on performance to the DSMES team, senior leadership, referring providers, payers, and other stakeholders. It is essential for the quality coordinator to understand the process of data collection, analysis, and communication.

The quality coordinator may serve as a member of the instructional team but is not required to do so. The CBO should determine which staffing pattern will work best, based on the size and specific nature of its DSMES program, the resources that are available, and its unique organizational structure.

Required documentation checklist to meet Standard 4:

- Position description for the quality coordinator overseeing DSMES
- Quality coordinator's resume
- 15 hours of required continuing education (see checklist for Standard 5 below)

Standard 5. DSMES Team

At least one of the team members responsible for facilitating DSMES services will be a registered nurse, registered dietitian nutritionist, or pharmacist with training and experience pertinent to DSMES, or be another health care professional holding certification as a diabetes educator (CDE) or Board Certification in Advanced Diabetes Management (BC-ADM). Other health care workers or diabetes paraprofessionals may contribute to DSMES services with appropriate training in DSMES and with supervision and support by at least one of the team members listed above.

The National Standards allow more leeway with regard to which professionals can serve as the licensed clinician to provide supervision than Medicare Part B services of the Medicare Program (see *Clinical Supervision Requirements*, pages 5-6). To attain Medicare reimbursement, the CBO should identify an RD to serve as the licensed clinician or partner with a local pharmacy for a pharmacist to serve as the licensed clinician. The CBO should ensure that the clinician has the necessary training, qualifications, and experience to serve as the instructor for DSMES services, which includes supervising the lay leaders. Additionally, to meet the accreditation requirements, which is necessary for Medicare reimbursement, the clinician must obtain 15 hours of continuing education obtained within 12 months of the accreditation application and 15 continuing education credits annually thereafter.

The lay leaders who facilitate the DSMP group classes and any other DSMES team members must also have the appropriate training and experience to provide DSMES services. They are also required to complete 15 hours of continuing education within 12 months of the accreditation application and 15 hours annually thereafter. The DSMP leader training, refresher training, and skill building training can count toward the 15 hours. In-service education offered by the CBO can also be counted.

Required documentation checklist to meet Standard 5:

- Position description for the licensed clinician/instructor, including supervisory responsibilities for the lay leaders
- Resume for the licensed clinician/instructor
- Position description for lay leaders and any other DSMES team members, including documentation of supervision by the RD (Note: Position descriptions should reflect coordination of services among all DSMES team members.)
- Resumes, written qualifications, or job applications that outline the qualifications of each lay leader and any other DSMES team members
- Proof of 15 hours of continuing education specific to their role for all DSMES team members. For any member of the team with a license, a copy of the continuing education certificate or official transcript must be submitted with the application. (Note: 15 hours of continuing education training is required annually to maintain certification.)

Standard 6. Curriculum

A curriculum reflecting current evidence and practice guidelines, with criteria for evaluating outcomes, will serve as the framework for the provision of DSMES. The needs of the individual participant will determine which elements of the curriculum are required.

This standard requires an evidence-based curriculum to be used as the foundation for an individualized DSMES plan with effective teaching strategies and methods for evaluating learning outcomes. The content should be tailored to the individual's needs and adapted for health literacy and cultural relevance. The content should be supplemented with appropriate resources and supporting education materials.

The Diabetes Self-Management Program is a culturally appropriate evidence-based program that can serve as the curriculum for DSMES services. The content is updated regularly to reflect current evidence and practice guidelines and to direct selection of appropriate education and self-management support strategies. The program is facilitated by two lay leaders with an interactive format. Each week, participants develop individualized action plans. Learning can be evaluated by the weekly feedback participants give as to what extent they have successfully completed their action plans.

Table 3 that follows shows the topics that the Standards state should be covered in the curriculum, including the AADE7 Self-Care Behaviors, and which session they are addressed in

the DSMP curriculum. See [Sample DSMES Policy and Procedure Manual](#), page 18 for a crosswalk between the DSMP session-by-session content and these requirements

Table 3. Topics Covered in the DSMES Curriculum and Which Session They Are Addressed in DSMP

Topic Covered	AADE7 Self-Care Behavior	DSMP Session
Diabetes pathophysiology and treatment options		1, 3, 5, and 6
Healthy eating	X	1-4
Physical activity	X	3 and 5
Medication usage	X	6
Monitoring and using patient-generated health data (PGHD)	X	1-6
Preventing, detecting, and treating acute and chronic complications	X (Reducing risks)	1-6
Healthy coping with psychosocial issues and concerns	X	4-6
Problem solving	X	1-6

Generally, when using DSMP as the curriculum, the process takes place over eight weeks and includes the following:

- A one-on-one meeting with the licensed clinician and each participant initially to develop an individualized DSMES plan (session 0/week 1)
- Six group sessions led by lay leaders and supervised by the licensed clinician (DSMP sessions 1-6/weeks 2-7)
- A final follow-up one-on-one session with the licensed clinician (week 8) to provide ongoing DSMES resources and support for each participant, based on his/her individualized needs

Alternately, a six or seven week-program could be offered in lieu of an eight-week curriculum. For a seven week program, the final follow-up session to provide a written plan for ongoing DSMES resources and support for each participant would be provided by the licensed clinician and/or lay leaders right after session 6 (during week 7 of the process). For a six-week program, the assessment and care plan would need to be offered the same week the group DSMP sessions start, and the follow-up plan would be provided during week six at the end of the DSMP session. While a six-week program could work in theory, it would be very ambitious and may not be practical to implement.

Once the initial assessment and care planning process has been completed, the licensed clinician may also offer additional individual DSMT and MNT sessions based on the needs of each participant. The DSMP group sessions are facilitated by the lay leaders under the supervision of the licensed clinician. The licensed clinician and lay leaders work collaboratively with each participant throughout the process to provide a person-centered approach to care

that recognizes participants as equal members of the team and keeps their needs at the forefront.

Required documentation checklist to meet Standard 6 (see [Sample DSMES Policy and Procedure Manual](#), pages 14-18):

- An overview of the DSMP evidence-based program and how it meets the requirements for this Standard as described above
- The content for each session and a crosswalk with the topics listed above in Table 3

Standard 7. Individualization

The DSMES needs will be identified and led by the participant with assessment and support by one or more DSMES team members. Together, the participant and DSMES team member(s) will develop an individualized DSMES plan.

This standard emphasizes the importance of person-centered care practices focused on each participant's needs and priorities, including an assessment, care plan, interventions, and outcomes, all of which must be developed in collaboration with the participant and the DSMES team and documented in the participant's health record.

There must be an initial comprehensive assessment conducted by a licensed clinician in collaboration with the participant. The assessment should incorporate information about the individual's demographics, medical condition and history, diabetes knowledge and self-management abilities, emotional response to the health condition, health literacy, cultural factors, support systems, financial status, barriers to self-management, and readiness to learn. After the initial assessment, reassessments can be provided later as indicated, based on the needs of the participant.

The education plan should be individualized and developed in full collaboration with the participant and the DSMES team. Because DSMP is an evidence-based program and must be implemented with fidelity to the original design, the curriculum itself cannot be modified. However, individualization can be achieved by identifying specific priorities or goals that each participant wants to focus on over the course of the program. These goals can be accomplished (or modified if desired by the participant) through the weekly action planning process, a core component of the DSMP model. Weekly action planning provides individualized instruction to participants on appropriate goal setting and a review of achievement of stated goals. This process must be documented for each participant in the health record to reflect individualized goal setting and progress toward those stated goals.

This standard also emphasizes the importance of evidence-based delivery methods, culturally relevant and health literacy appropriate language and materials, problem solving strategies, self-efficacy building, behavior change goals and objectives, and interactive teaching styles. The DSMP model meets these requirements.

Required documentation checklist to meet Standard 7:

- Policy regarding individualization documented in the policy and procedure manual
- A de-identified health record for one or more participants, containing the following:
 - Comprehensive initial assessment (see above for required elements) developed collaboratively with the participant and the licensed clinician/instructor
 - Individualized DSMES plan developed in collaboration with the participant and the DSMES team with weekly action planning documented for each participant
 - Educational and behavioral interventions based on the participant's needs and priorities
 - Action-oriented, behavior change goals that are mutually developed with the participant
 - Reassessments based on the individual's needs as deemed appropriate by the licensed clinician

Standard 8. Ongoing Support

The participant will be made aware of options and resources available for ongoing support of their initial education, and will select the option(s) that will best maintain their self-management needs.

This standard was developed due to the recognition that initial DSMES is not enough for participants to retain knowledge, sustain skills and behavior changes, and effectively manage their diabetes over the course of a lifetime. Therefore, it is important that options and resources for ongoing support of self-management be made available.

The ongoing support plan, developed in collaboration with each participant, should be customized to the individual's needs and goals to facilitate ongoing, effective self-management. A variety of strategies can be offered, such as linkage to community resources, psychosocial support programs, weight management or physical activity programs, medication management, and other options specific to the local community and individualized for each participant.

To meet this requirement, the CBO should develop a listing of locally available resources and options from which participants can select to support the concepts presented during the DSMES program. Participants should select resources based on the individualized goals they want to sustain or work toward once the formal DSMES services conclude.

When using DSMP as the curriculum, this standard can be met in several ways, depending on the CBO's specific implementation model (see Standard 6). One option is to provide the ongoing DSMES resources during a one-on-one follow-up visit with the licensed clinician. Another option is for the lay leaders and/or licensed clinician to meet with participants immediately after the final DSMP session to develop an ongoing DSMES plan with each participant. Regardless of which option is selected for meeting this standard, the provision of resources should be done in a manner that does not compromise the fidelity of DSMP (i.e., does not deviate from the scripted curriculum).

Required documentation checklist to meet Standard 8:

- A listing of local resources and options for ongoing support of the initial DSMES services. (The listing can be made into a form that is provided to and reviewed with each participant to allow individualized selection of options from a menu of available resources.)
- A de-identified health record(s) documenting the options and resources selected by the participant for ongoing support once formal DSMES services ends.

Standard 9. Participant Progress

The provider(s) of DSMES services will monitor and communicate whether participants are achieving their personal diabetes self-management goals and other outcome(s) to evaluate the effectiveness of the educational intervention(s), using appropriate measurement techniques.

This standard discusses the importance of monitoring the achievement of behavior change SMART (specific, measurable, achievable, realistic, and time-bound) goals to evaluate the effectiveness of the DSMES interventions. The CBO is expected to have strategies in place to assist participants with the goal setting process and to measure and communicate relevant DSMES individual and aggregate outcomes (e.g., knowledge, behavior, clinical, quality of life, cost savings, and satisfaction) at appropriate intervals. A summary of the services provided and individual outcomes must be communicated back to the referring provider at the conclusion of DSMES services.

The AADE7 Self-Care Behaviors can be used as the framework for measuring progress. The AADE7 Self-Care Behaviors identify the following seven areas to focus on when monitoring behavior change: healthy eating, being active, taking medication, monitoring, problem solving, reducing risk, and healthy coping. When evaluating behavior change, CBOs can select from the list of behaviors; not all seven behaviors need to be focused on at once.

Goal setting and weekly action planning are integral components of DSMP. By monitoring and documenting this process for each participant, the DSMES team can evaluate goal attainment for each individual. Weekly, the lay leaders should document each participant's weekly action plan in coordination with the licensed clinician. The licensed clinician is responsible to review and counter sign the documentation. Timely communication and coordination between the clinician and lay leaders are essential for the provision of quality DSMES services.

Using an appropriate framework, individual data can be categorized, entered into a spreadsheet or some other type of database, and analyzed to evaluate and communicate outcomes for the entire population who received DSMES services. It is important to establish a baseline for measurement and to set clear parameters for what will be measured and when (at what intervals).

Required documentation checklist to meet Standard 9:

- A process in place to track and monitor personalized goals for each participant, which should include at least one SMART behavior goal and one clinical outcome measure. The baseline measurements and at what intervals the measurements will be made should be provided.
- Submission of at least one de-identified health record that shows documentation of at least one SMART behavior goal and one clinical outcome with follow up and measured achievement. (Note: It is recommended that three de-identified charts be submitted with the application to ensure appropriate documentation examples to meet the requirements.)
- A policy for communication of the services provided, progress made, and outcomes achieved back to the referring provider with documentation reflected in the de-identified health record(s). The communication back to the provider should be reflected in the de-identified health record(s) that are submitted with the application.

Standard 10. Quality Improvement

The DSMES services quality coordinator will measure the impact and effectiveness of the DSMES services and identify areas for improvement by conducting a systematic evaluation of process and outcome data.

This standard discusses the importance of measuring and monitoring process and outcome data on an ongoing basis as a means of adjusting and improving DSMES services to better meet the needs of the population served and to help sustain the services long term. Having a formal process in place is required to ensure quality services with positive outcomes.

This standard refers to three fundamental questions from the Institute for Healthcare Improvement that should be asked through the CQI process: 1) What are we trying to accomplish? 2) How will we know a change is an improvement? 3) What changes can we make that will result in improvement? A variety of methods can be used for CQI, such as the Plan Do Study Act model, Six Sigma, Lean, Re-AIM, and workflow mapping.

In developing a formal CQI process to prepare for accreditation, a CBO should select areas for improvement, including outcome measures and process measures. Outcome measures are quantitative and indicate the result of a process. They can focus on clinical outcomes (e.g. A1C levels, foot or eye exams, or weight) or behavior outcomes (e.g., participant satisfaction, participant self-reported confidence in ability to self-manage, healthy eating habits, or physical activity levels). Process measures use qualitative methods to provide information about what factors lead to the results (e.g., no show rates, enrollment process, or attrition rates).

Additionally, timelines for measurement, data collection, analysis, and presentation of results should be determined.

Required documentation checklist to meet Standard 10:

- A formal CQI process to collect, analyze, and report data, including baseline data for at least one clinical outcome measure and one process measure that the program will track annually. A behavioral change measure may also be identified.
- Documentation that the three fundamental questions (see above) are answered through the CQI process.

[Sample DSMES Policy and Procedure Manual](#). To help CBOs prepare their policy and procedure manual, NCOA has developed a sample manual as a guide for meeting the 10 National Standards for DSMES when DSMP is used as the curriculum. The manual is intended only as a guide, and each CBO should individualize the policies and procedures for its specific program, while ensuring the Standards are met and the fidelity of DSMP is maintained.

Planning and Implementing the DSMP Test Class

As part of the accreditation process, the applicant is required to implement a “test class” and submit at least one de-identified participant health record with the accreditation application. Prior to implementing the test class, the CBO must have selected a curriculum (e.g., DSMP) and determined how it will be implemented (i.e., what happens when and over how many weeks). When DSMP is selected as the curriculum, the program is generally offered over eight weeks (see pages 11-12).

The test class is implemented in the same way that classes will be offered after the program is accredited, with the exception of billing. The test class cannot be billed to Medicare because accreditation is a requirement for Medicare Part B reimbursement of DSMT. Note: Even though the test class is not billable, it provides an opportunity to offer a trial run of the billing process without actually submitting the claims to ensure both clinical and back office staff understand what is expected.

Tips for planning the test class:

- Schedule the class well in advance to allow time for planning and recruiting participants.
- Target marketing messages to physician practices, including statistics about the diabetes rates for the area; local DSMP efforts, history, and any positive results or outcomes; and the benefits of holding DSMES in a community setting. CBOs may also want to consider advertising the program as a new “pilot opportunity” to enlist community interest and support.
- Develop a partnership with at least one health care provider that serves Medicare beneficiaries to help identify and enroll potential participants.
- Develop a process for obtaining a physician or non-physician provider order for DSMES services that are needed.
- Develop and review the documentation process, responsibilities, and communication flow with the licensed clinician and other DSMES team members (e.g., lay leaders).

- Orient the licensed clinician to the billing codes, hours of DSMT training covered, and the superbill (information that the clinician has to document to submit claims).
- Create a formalized billing process and collect insurance information from each participant during enrollment. (While the test class is not billable, collecting the insurance information as a test run will help prepare the CBO for billing once the program becomes accredited and recognized by Medicare.)

Documentation Flow and Sample Forms

All clinical services provided should be documented in a manner that is compliant with the Health Insurance Portability and Accountability Act (HIPAA). There must be appropriate documentation in the health record to support claims that are submitted for DSMT services, including verification of the diabetes diagnosis (see page 5) and a referral from the physician or non-physician provider. The [Order Form](#) developed by AADE and the Academy of Nutrition and Dietetics can be used to document the required referral information.

The documentation flow and elements that are included in the clinical documentation of DSMT services are outlined below.

[Initial DSMES Assessment and Individualized Education Plan](#)

- Developed by the licensed clinician in collaboration with the participant and the DSMES team.
- The assessment should include demographics, medical condition and history, diabetes knowledge and self-management ability, emotional response to the diabetes, physical limitations, social support system, financial status, health literacy, cultural factors, barriers to diabetes management, and readiness to learn.
- Identification of the needs, concerns, and priorities of the participant.
- Education, lifestyle, and support interventions to address the identified needs.
- Person-centered SMART goals.
- Planned frequency and duration, e.g., the frequency of individual and group sessions and the duration of each session.
- The participant's agreement with the goals and plan.

[DSMES Group Interventions/Weekly Action Plan](#)

- The DSMP content covered, including diabetes pathophysiology, treatment options, and the AADE-7 Self-Care Behaviors. (See page 18 of [Sample DSMES Policy and Procedure Manual](#). This chart can be included in each participant's health record. However, any sessions that the participant misses should be noted on the chart to document which content was not delivered to the participant.)
- The weekly action planning/goal setting process and the degree to which the participant achieved each weekly goal.

- Barriers that impede achievement of the goals, e.g., health literacy, cultural factors, financial status, inadequate social support, etc.

DSMES Individual Interventions/Progress Notes

- The specific counseling, as well as educational and behavioral interventions that are provided to help the participant achieve his/her personalized self-management goals.
- The participant's response each time the intervention is offered and progress toward the personalized goal(s).
- Any change in the frequency or duration of services.
- Barriers that impede achievement of the goals, e.g., health literacy, cultural factors, financial status, inadequate social support, etc.
- Communication and coordination with DSMES team and referring provider.

Ongoing Diabetes Self-Management Support Plan

- At the conclusion of DSMES services, provide each participant with written options and resources for ongoing support of his/her diabetes to help maintain individualized self-management needs.

DSMES Follow-Up Plan

- Communicated and coordinated with the referring provider.
- Summary of the services provided.
- Reassessment of how the participant is self-managing, including:
 - Progress made.
 - Whether or not or to what extent the personalized goals were met.
 - Continuing care needs: how the disease will continue to be managed, including recommendations and/or referrals for ongoing support, care, and self-management.

Putting the Pieces Together: Practical Steps and Strategies for Implementing and Sustaining a Successful DSMT Services Program

This section is focused on laying out the key steps that are necessary to effectively implement DSMT services, as well as strategies that should be employed to develop a viable DSMT program with long-term sustainability. It is important for CBOs to fully understand the commitment involved in becoming a DSMT services provider and the resources required for a successful program.

Before embarking down the path of becoming a Medicare provider, CBOs should seriously consider the impact of the changes in organizational culture that are required to transition from a social service delivery model to operating as a health care provider. To help CBOs understand

and navigate these organizational changes, NCOA developed the following helpful resource: https://www.ncoa.org/wp-content/uploads/A-Framework-of-Change_Stages-of-Organizational-Change_Final-Draft-002-1.pdf. The organizational changes discussed in this resource revolve around five core programmatic elements: program delivery or implementation, accreditation, clinical supervision, billing, and documentation and tracking.

Key Steps to Develop and Implement a Medicare Recognized DSMT Services Program

Assess the level of organizational readiness. Because a considerable amount of time and resources are necessary to attain national accreditation and become a Medicare Part B DSMT provider, CBOs should conduct an internal assessment to determine their level of readiness. To help with this process, NCOA has developed a [DSMT Readiness Review tool](#).

Understand the national accreditation and Medicare requirements. CBOs should also have a thorough understanding of the 2017 National Standards for DSMES, the accreditation process, and the Medicare Requirements for DSMT. Further, it is critical that they understand the additional elements or clinical wrap-around structure that need to be put in place when using DSMP as the curriculum.

Enlist the support of leaders and develop key partnerships to ensure an adequate infrastructure for implementing the program in the designated area. It is essential that senior leadership within the organization fully endorse and support DSMT services and commit sufficient internal human and financial resources to carry out the core functions of the program. Equally important, there should be a focus on strengthening and expanding community partnerships to build the capacity of the program. An infrastructure to support a successful DSMT services program includes an adequate supply of trainers, leaders, class sites, and referral sources. Additionally, there must be access to a licensed clinician and identification of the quality coordinator overseeing DSMES services. Partners may contribute in a variety of ways, such as making referrals, marketing the program, serving as a member of the stakeholder group, donating in-kind services (e.g., time, space, supplies or materials), providing financial support, or offering other types of assistance.

Prepare and Apply for Accreditation. See *National Accreditation/Recognition*, pages 2-5.

Become a recognized Medicare Part B provider of DSMT or partner with an organization to serve as the Medicare provider. Once a CBO becomes accredited, the accreditation certificate should be reviewed to ensure that it is accurate and a copy submitted to the designated MAC in order to become a recognized DSMT provider. The CBO must already be a Medicare Part B provider for another primary service, such as MNT, before being approved as a DSMT provider.

A CBO that is interested in providing DSMT but doesn't wish to become a Medicare provider can partner with a recognized Medicare provider to file the claims with Medicare. This type of arrangement would require a contractual agreement to define roles, responsibilities, and how the revenue will be shared.

Promote and market your services to the target audience. CBOs who have accredited DSMES programs and serve as Medicare recognized providers bring tremendous value to their communities, as well as to health care providers and health plans. A value proposition can be developed to help CBOs effectively promote the value of DSMT and target customers who can benefit from the services. NCOA's [Developing Your Value Proposition for Evidence-Based Programs, How-to-Guide and Worksheet](#) is designed to help CBOs develop a strong value proposition.

Continuously monitor, evaluate, and improve DSMT services. To build a successful DSMT program, it is essential to develop formal quality improvement strategies and a systematic evaluation process with specific outcome and process measures.

Five Proven Strategies to Develop a Sustainable Business Model

CBOs that have been successful in developing and sustaining DSMT services understand and have applied certain business acumen principles. Five strategies that have proven effective are described below.

- 1. Calculate the program costs.** To develop a successful business model for DSMT, it is important to have a clear understanding of all of the costs associated with offering the services, as well as the potential for earned revenue to cover those costs. Without knowing the program costs, CBOs are “operating in the dark.” Typical costs for DSMT include personnel; marketing; training; fees associated with delivering group classes (the DSMP workshop); equipment; space, supplies, and materials to operate the program; and indirect overhead (a percentage of the total costs). The largest fixed cost for DSMT is generally personnel. To reduce personnel costs, a CBO may decide to hire a part-time hourly clinician until the program grows enough to warrant a full-time position. NCOA has developed a [Chronic Disease Program Cost Calculator](#) to help organizations better understand and manage the costs of operating a CDSME program.
- 2. Identify startup funding.** CBOs seeking to become a DSMT provider should develop a plan to cover the costs until they are able to reach the break-even point (the point at which the revenue earned is enough to cover the costs). They may identify funding from a variety of sources, such as grants, foundations, seed monies, Older Americans Act, or other funding streams to help support DSMT services.
- 3. Conduct a break-even analysis.** A break-even analysis is a way to determine how many DSMT classes or workshops need to be offered annually to cover the costs of associated with offering the program. The break-even is the point upon which revenue and expenses are equal or the no loss, no profit point. Revenue earned after the break-even point represents program earnings or profit. NCOA's [Break-Even Analysis Worksheet](#) can be used to help conduct the break-even analysis.

- 4. Assess the level of risk and plan accordingly.** Once a CBO has conducted the break-even analysis, it is important to assess the level of risk associated with offering DSMT services and to plan accordingly. The following questions should be asked: Is there enough market demand to meet the projections? Are there sufficient leaders and trainers to deliver the number of programs required to break even? Historically, how many classes were offered in previous years, compared to what needs to be offered to break even; and realistically, how long will it take to fill the gap? Once these questions are answered and the risk associated with offering DSMT services is understood, a realistic plan and timeline to achieve the break-even point should be developed. Reaching the break-even point can take some time. Therefore, as noted above, it is important to identify additional funding sources to cover DSMT services until the revenue covers the costs.

- 5. Identify strategies to increase the volume of DSMT services.** CBOs should determine how they will monitor the efficiency and effectiveness of the services delivered and what strategies they will use to increase the volume of services over time. As health care providers and plans learn about the positive results of DSMT services for the communities they serve, they are more likely to want to partner with CBOs to improve diabetes outcomes for the population they serve. Over time, a program is more sustainable if there are multiple referral sources, as well as multiple payers. For example, CBOs should work toward developing partnerships with a number of provider practices that stand to benefit from DSMT services to improve their quality measures for diabetes. Further, CBOs should enroll as network providers in Medicare Advantage plans that are dominant in their coverage area. They should also be prepared to bill Medicaid and inquire about enrolling as providers in Medicaid managed care plans and other managed care plans in their designated area.

Another way that CBOs can increase the volume of the program is to expand the geographic coverage area. However, in doing so, they will need to consider travel costs, as well as any additional staff that might be needed to deliver the services. The additional costs weighed against the potential increase in revenue will need to be examined to determine if this is a fiscally sound approach. Sometimes, there are partners who are willing to fulfill specific roles and share both the risks and costs associated with geographic expansion.

This project was supported, in part by grant number 90CS0058, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.