



A guide to better outcomes through referral of your patients with diabetes to an Evidence-Based Diabetes Self-Management Education Program (DSME)

DIABETES SELF-MANAGEMENT EDUCATION

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Managing Diabetes: Making a difference by linking the clinic with the Diabetes Education Team.

In the average primary care practice in Nevada, up to one in ten patients over age 18, and one in five over age 65, have diabetes.

Use this guide to provide your patients with ongoing Diabetes Self-Management Education and Support to control their diabetes and reduce complications.

Diabetes self-management education and support are essential components of diabetes therapy because they can produce both behavioral and biological benefits and outcomes.¹ Effective self-management education and ongoing self-management support enable people living with, or at risk, for diabetes to make informed decisions and to assume responsibility for the day-to-day management of their disease or risk factors.²

Definition and Purpose of Diabetes Self-Management Education (DSME) and Diabetes Self-Management Support (DSMS)

Self-management is an active, ongoing process that changes as the person's needs, priorities, and situations change. Diabetes Self-Management Education (DSME) is an ongoing process to facilitate a person's knowledge, skill, and ability for self-care. This process incorporates the needs, goals, and life experiences of the person with diabetes and is guided by evidence-based standards. Objectives are to support informed and shared decision making, self-care behaviors, problem solving, and active collaboration with the health care team to improve clinical outcomes, health status, and quality of life. Diabetes educators and others in the health care team can help people living with or at risk for diabetes to:^{3,4}

- Understand the diabetes disease process and the risks and benefits of treatment options.
- Incorporate healthy eating behaviors into their lifestyles.
- Incorporate physical activity into their lifestyles.
- Understand how to use medications safely and effectively.
- Perform self-monitoring of blood pressure when prescribed.
- Perform self-monitoring of blood glucose when prescribed and demonstrate how to interpret and use the results for self-management decision making.
- Understand how to prevent, detect, and treat high and low blood glucose.
- Understand self-management needs during illness or medical procedures.
- Prevent, detect, and treat chronic diabetes complications.
- Develop personal strategies to address psychosocial issues and concerns.
- Develop personal strategies to promote health and behavior change.⁵

Diabetes Self Management Support (DSMS) involves health care providers in activities that help people with diabetes to implement and sustain ongoing behaviors needed to manage their diabetes. These activities include behavioral, educational, psychosocial, and clinical support.

1 Funnell MM, Anderson RM: Empowerment and self-management of diabetes. *Clinical Diabetes* 2004; 22(3): 123-127.

2 Heinrich E, Schaper NC, de Vries NK. Self-management interventions for type 2 diabetes: a systematic review. *Eur Diabetes Nurs.* 2010;7:71–6.

3 American Diabetes Association/American Association of Diabetes Educators National Standards

4 Standards of Practice and Standards of Professional Performance for Registered Dietitians (Generalist, Specialty, and Advanced) in Diabetes Care

5 Cochran J, Conn VS. Meta-analysis of quality of life outcomes following diabetes self-management training. *Diabetes Educ.* 2008;34:815–23.

Overview of guide tools

Resource Section	Purpose
Engaging clinicians	
Team Care Approach For Diabetes Management	Describes how team care improves diabetes outcomes for patients
Why refer Patients to Diabetes Self-Management Education (DSME)?	Details the benefits to providers of referring to DSME and health outcomes for patients of DSME participation
Working with a Certified Diabetes Educator and Diabetes Education Team	Describes the role of diabetes educators as part of the overall care team and the unique skill sets they bring to patients and providers
Eligibility and Insurance Coverage for DSME	Describes what DSME classes are covered by different insurance providers
How to code for DSME	Provides codes to improve reimbursement rates
Importance of follow-up after a referral to DSME	Describes how follow up after a referral to DSME improves short and long term health outcomes for patients
Engaging patients	
Are You At Risk for Type 2 Diabetes Checklist	A checklist of risk factors for Type 2 Diabetes
Patient Handout	Includes the "I Can Control My Diabetes By Working With My Health Care Team" handout
Nevada "Ask Your Doctor" DSME Poster	Provides graphic information for patients on where to find DSME resources in Nevada
Incorporating screening, testing and referral into practice	
Patient Flow Process	Provides a high-level overview of how office staff can facilitate point-of-care identification
Point of Care / Critical Times to Refer to DSME	Offers providers an option to adapt/incorporate a diabetes screening and referral process into their workflow
Sample DSME and Nutrition Therapy Referral Form	Provides a sample referral form for DSME and nutrition classes
Diabetes Head to Toe Checklist Examination Report	Checklist for patients with diabetes to assess overall health
BMI Calculation Chart	Provides calculation information for BMI
DSME Billing Codes	Provides information on how to code for DSME

**Engage
clinicians**



Team Care Approach for Diabetes Management⁶

A team approach to diabetes care can effectively help people cope with the vast array of complications that can arise from diabetes. People with diabetes can lower their risk for microvascular complications, such as eye disease and kidney disease; macrovascular complications, such as heart disease and stroke; and other diabetes complications, such as nerve damage, by:

- Controlling their ABCs (A1C, blood pressure, cholesterol, and smoking cessation).
- Following an individualized meal plan.
- Engaging in regular physical activity.
- Avoiding tobacco use.
- Taking medicines as prescribed.
- Coping effectively with the demands of a complex chronic disease.

Patients who increase their use of effective behavioral interventions to lower the risk of diabetes and treatments to improve glycemic control and cardiovascular risk profiles, can prevent or delay progression to kidney failure, vision loss, nerve damage, lower-extremity amputation, and cardiovascular disease. This in turn, can lead to increased patient satisfaction with care, better quality of life, improved health outcomes, and ultimately, lower health care costs.

6 https://www.cdc.gov/diabetes/ndep/pdfs/working_together_to_manage_diabetes_webinar_slides.pdf
<https://www.aafp.org/news/practice-professional-issues/20190522ruraldiabetes.html>

Why refer patients to Diabetes Self-Management Education (DSME)?

DSME works! Diabetes Self-Management Education is an *evidence-based intervention* that increases the knowledge and skills of patients with diabetes to improve their health outcomes and their ability to self-manage their disease. To promote quality education for people with diabetes, the American Diabetes Association (ADA) endorses the National Standards for Diabetes Self-Management Education and Support as the basis for ADA–Recognition. The Association of Diabetes Care and Education Specialists (ADCES) Accreditation Program is also based on the National Standards. Both certifying bodies recognize DSME as a collaborative process by which people with diabetes gain the skills and knowledge needed to modify behavior and successfully manage the disease and its related conditions.

Patients who receive Diabetes Self-Management Education:

- Have improved use of primary care and prevention services
- Are more likely to take medication as prescribed
- Have better control of glucose, blood pressure, and LDL cholesterol
- Have lower health costs

ADCES7™ Self-Care Behaviors:

The ADCES developed seven self-care behaviors (the ADCES7) that make up the core of DSME programs:



Working with Certified Diabetes Educator and Diabetes Education Team



DSME is a team-based approach where educators work with clinicians to promote the best possible health outcomes for patients. Diabetes educators are licensed health care professionals, including registered nurses, registered dietitians, and pharmacists. Many of the health care professionals who provide DSME services through accredited programs also carry the designation Certified Diabetes Care & Education Specialist (CDCES). In addition to certified DSME providers, professional health education specialists and community health workers (CHWs) also play a role in meeting unmet needs for diabetes education in underserved communities. CHWs can bridge language, cultural and traditional barriers to achieve positive health outcomes for patients with diabetes. This team approach specializes in helping people with diabetes to learn the skills that best self-manage their diabetes. While the clinician focuses on providing the highest clinical care to the patient, the DSME provider focuses on providing the counseling, education, training and support known as Diabetes Self-Management Education (DSME) or Diabetes Self-Management Training (DSMT⁷).

Benefits of Partnering Within a DSME Team Model

Efficiency	Increased efficiency for clinicians with DSME providers educating, training and following up with clients
Meeting Goals	DSME providers help clinicians meet pay-for-performance and quality improvement goals
Measuring Progress	DSME team members provide improved patient tracking and help clinicians monitor patient care and progress
Reporting	Improved patient health status reporting
Preventing Diabetes	Improved ability to delay the onset of diabetes with prevention and self-management training for patients who are at high risk

How Do Diabetes Educators Help?

Learn Basic Information	Understand How to Use Devices	Adopt Healthy Eating and Physical Activity Habits
<ul style="list-style-type: none"> • Seven tenets of self-care behavior (ADCES7) • Incorporating diabetes management into life 	<ul style="list-style-type: none"> • Blood glucose meters • Insulin pens • Insulin pumps • Continuous glucose monitors 	<ul style="list-style-type: none"> • Nutrition education • Meal planning • Weight loss strategies

7 <https://chronicdisease.org/page/diabetes/tools-and-guidance-for-cdc-funded-partners/>



Eligibility and Insurance Coverage for DSME

The outpatient DSME program must be accredited as meeting approved quality standards in order to be reimbursed by insurance, including Medicaid and Medicare. CMS accepts recognition by the ADA or accreditation by the AADE as meeting the National Standards for Diabetes Self-Management Training Programs.⁸

Nevada State Law provides coverage for the self-management of diabetes as follows:

- The training and education provided to the insured after he is initially diagnosed with diabetes, which is medically necessary for the care and management of diabetes, including, without limitation, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes;
- Training and education which is medically necessary as a result of a subsequent diagnosis that indicates a significant change in the symptoms or condition of the employee or member of the insured group and which requires modification of his program of self-management of diabetes; and
- Training and education which is medically necessary because of the development of new techniques and treatment for diabetes.
- Check with the insured's health plan for detailed coverage.

Medicare⁹

Medicare Part B (Medical Insurance) covers diabetes outpatient self-management training only if the physician or qualified non-physician practitioner (the "certified provider") who is managing the beneficiary's diabetic condition, certifies that such services are needed by sending an original referral form to the diabetes education program. The order must be part of a comprehensive plan of care and describe the training that the provider is ordering and/or any special concerns such as the need for general training, or insulin-dependence. Outpatient diabetes self-management training is classified as initial or follow-up training.

- When a beneficiary has not yet received initial training, they are eligible to receive 10 hours of initial training within a continuous 12-month period. The 12-month period does not need to be on a calendar-year basis.
- The 10 hours of initial training may be provided in any combination of half-hour increments within the 12-month period and less than 10 hours of initial training may be used in the 12-month period if, for example, the beneficiary does not attend all of the sessions or the physician does not order the full training program.
- Nine hours of the initial training must be provided in a group setting, consisting of 2 to 20 individuals who need not all be Medicare beneficiaries, unless the provider certifies that a special condition exists that makes it impossible for the beneficiary to attend a group training session.
- For all beneficiaries, one hour of initial training may be provided on an individual basis for the purpose of conducting an individual assessment and providing specialized training.
- Medicare also covers 2 hours of follow-up training each year starting with the calendar year following the year in which the beneficiary completes the initial training. The 2-hours of training may be given in any combination of half-hour increments within each calendar year on either an individual or group basis.

⁸ <https://chronicdisease.org/tag/diabetes>

⁹ <https://www.cdc.gov/diabetes/dsmes-toolkit/reimbursement/medicare.html>

Nevada Medicaid

Nevada Medicaid defines Diabetic Outpatient Self-Management Training Services as the development of a specific treatment plan for Type 1 and Type 2 diabetics to include blood glucose self-monitoring, diet and exercise planning, and motivates recipients to use the skills for self-management.

- Reimbursement will follow Medicare guidelines for initial recipient and group training sessions.
- Services must be furnished by certified programs which meet the National Diabetes Advisory Board (NDAB) standards, and hold an Education Recognition Program (ERP) certificate from the American Diabetes Association. Program instructors should include at least a nurse educator and dietician with recent didactic and training in diabetes clinical and educational issues. (ADCES-accredited program inclusion in Nevada Medicaid's DSME policy is currently under review).
- Certification as a diabetes educator by the National Board of Diabetes Educators is required.
- **PRIOR AUTHORIZATION IS REQUIRED** when recipients require additional or repeat training sessions that exceed ten hours of training. Indications for repeat training Prior Authorization (PA) is required for recipients whose diabetes is poorly controlled include:
 - a. Hemoglobin A1c blood levels of 8.5 or greater.
 - b. Four or more serious symptomatic hypoglycemic episodes in a two month period.
 - c. Two or more hospitalizations for uncontrolled diabetes in a six month period.
 - d. Any ketoacidosis or hyperosmolar state.
 - e. Pregnancy in a previously diagnosed diabetic.
 - f. Diabetics beginning initial insulin therapy.
- No coverage will be provided for initial training which exceeds ten hours, or for repeat training, without a prior authorization.

How to Code for DSME

Depending on the type of office visit, practices can use several CPT and ICD codes to bill for prediabetes screening and counseling. A list of commonly used CPT and ICD 10 codes are included in this guide on page 23.

Importance of follow-up after a referral to DSME

Even though clinicians talk to patients about the importance of self-care after a diagnosis of diabetes, research shows us that patients with diabetes have compliance challenges following their doctors' advice, even after they are told how important it is to self-manage their disease.

- **Medication** – only 77 percent of patients with diabetes take insulin as prescribed and 85 percent take other medications as prescribed
- **Monitoring** – fewer than half – 45 percent – monitor their blood glucose as told
- **Exercise and weight loss** – only 24 to 27 percent of patients follow the instructions closely¹⁰

Referring a patient to work with a diabetes educator and supporting that interaction with provider follow-up will ensure better outcomes for the patient. **By incorporating reminders and follow up procedures into office procedures**, clinicians can dramatically increase the likelihood that patients will attend and complete self management education and have access to critical information and supports throughout the course of their disease.

10 Association of Diabetes Care & Education Specialists accessed at <https://www.diabeteseducator.org/practice/provider-resources/importance-of-follow-up>



Engage patients

Patient risk assessment

ARE YOU AT RISK FOR

TYPE 2 DIABETES?



Diabetes Risk Test

- 1 How old are you?**
 Less than 40 years (0 points)
 40—49 years (1 point)
 50—59 years (2 points)
 60 years or older (3 points)
- 2 Are you a man or a woman?**
 Man (1 point) Woman (0 points)
- 3 If you are a woman, have you ever been diagnosed with gestational diabetes?**
 Yes (1 point) No (0 points)
- 4 Do you have a mother, father, sister, or brother with diabetes?**
 Yes (1 point) No (0 points)
- 5 Have you ever been diagnosed with high blood pressure?**
 Yes (1 point) No (0 points)
- 6 Are you physically active?**
 Yes (0 points) No (1 point)
- 7 What is your weight status?**
(see chart at right)

Write your score in the box.

↓

Height	Weight (lbs.)		
4' 10"	119-142	143-190	191+
4' 11"	124-147	148-197	198+
5' 0"	128-152	153-203	204+
5' 1"	132-157	158-210	211+
5' 2"	136-163	164-217	218+
5' 3"	141-168	169-224	225+
5' 4"	145-173	174-231	232+
5' 5"	150-179	180-239	240+
5' 6"	155-185	186-246	247+
5' 7"	159-190	191-254	255+
5' 8"	164-196	197-261	262+
5' 9"	169-202	203-269	270+
5' 10"	174-208	209-277	278+
5' 11"	179-214	215-285	286+
6' 0"	184-220	221-293	294+
6' 1"	189-226	227-301	302+
6' 2"	194-232	233-310	311+
6' 3"	200-239	240-318	319+
6' 4"	205-245	246-327	328+

(1 Point) (2 Points) (3 Points)

You weigh less than the amount in the left column (0 points)

If you scored 5 or higher:
 You are at increased risk for having type 2 diabetes. However, only your doctor can tell for sure if you do have type 2 diabetes or prediabetes (a condition that precedes type 2 diabetes in which blood glucose levels are higher than normal). Talk to your doctor to see if additional testing is needed.

↓

Add up your score.

↓

Adapted from Bang et al., Ann Intern Med 151:775-783, 2009.
 Original algorithm was validated without gestational diabetes as part of the model.

Type 2 diabetes is more common in African Americans, Hispanics/Latinos, American Indians, and Asian Americans and Pacific Islanders.

For more information, visit us at www.diabetes.org or call 1-800-DIABETES

Visit us on Facebook
[Facebook.com/AmericanDiabetesAssociation](https://www.facebook.com/AmericanDiabetesAssociation)

Lower Your Risk

The good news is that you can manage your risk for type 2 diabetes. Small steps make a big difference and can help you live a longer, healthier life.

If you are at high risk, your first step is to see your doctor to see if additional testing is needed.

Visit diabetes.org or call 1-800-DIABETES for information, tips on getting started, and ideas for simple, small steps you can take to help lower your risk.





I Can Control My Diabetes By Working With My Health Care Team!



To team up with my pharmacist, I will—

- Make a list of all my medicines, the exact doses, and include over-the-counter medicines, vitamins, and herbal supplements.
- Update and review the list with my pharmacist every time there is a change.
- Ask how to take my medicine and use supplies to get the best results at the lowest cost.
- Ask about new medicines that I can talk about with my doctor.



To team up with my podiatrist, I will—

- Get a full foot exam by a podiatrist at least once each year.
- Learn how to check my feet myself every day.
- See my podiatrist right away if I develop any foot pain, redness, or sores.
- Ask about the right shoes for me.
- Make sure my feet are checked at every health care visit.



To team up with my eye care provider, I will—

- Ask for a full eye exam with dilated pupils each year.
- Ask how to prevent diabetic eye disease.
- Ask what to do if I have vision changes.



To team up with my dental provider, I will—

- Visit my dental provider at least once a year for a full mouth exam.
- Learn the best way to brush my teeth and use dental floss.
- Ask about the early signs of tooth, mouth, and gum problems.
- Ask about the link between diabetes and gum disease.

To control my diabetes every day, I will—

- Be more active—walk, play, dance, swim, and turn off the TV.
- Eat a healthy diet—choose smaller portions, more vegetables, and less salt, fat, and sugar.
- Quit if I smoke or use other tobacco products—tobacco use increases the risk of health problems from diabetes. To quit, call the Nevada Tobacco Quitline: **1-800-QUIT-NOW (1-800-784-8669)**.
- Ask all my providers to share my exam results with my other health care providers.
- Learn about managing my diabetes by visiting www.cdc.gov/diabetes/ndep
- Control my ABCs of diabetes:
 - ▶ **A1C.** This test measures average blood sugar levels over the last 3 months. The goal is less than 7% for many people but your health care provider might set different goals for you.
 - ▶ **Blood Pressure.** High blood pressure causes heart disease. The goal is less than 140/90mm Hg for most people.
 - ▶ **Cholesterol.** Bad cholesterol or LDL (Low Density Lipoprotein) builds up and clogs your arteries.

To get more **FREE** information on how to prevent or control diabetes, call the Centers of Control and Disease Prevention (CDC) at 1-800-CDC-INFO (800-232-4636), TTY line 1-(888) 232-6348 or visit: <https://www.cdc.gov/diabetes/index.html>



National Diabetes Education Program NDEP

A program of the National Institutes of Health and the Centers for Disease Control and Prevention

CS241400-B NDEP-128



Managing Diabetes

**Diabetes Self-Management Education
Ask Your Doctor**

MAKE A PLAN... IT'S WORTH IT!

People who learn to manage their diabetes have fewer health problems from diabetes even years later. You can too. Learn how to better manage your diabetes by attending a Diabetes Self-Management Education Program.

Ask your doctor about referring you to a program.

**Incorporate
screening, testing
and referral into
practice**

Sample patient flow process

MEASURE

CHECK-IN

- Has the patient ever been told/diagnosed with diabetes?
- Patient completes ADA Diabetes risk test if new patient and undiagnosed
- Insert completed test in paper chart or note risk score in EMR/EHR



ROOM/VITALS

- Calculate BMI (using table) and review diabetes risk score
- If elevated risk score or history of GDM flag for possible referral to DMSE



ACT

EXAM/CONSULT

- Follow Standards of Medical Care in Diabetes – 2021, formerly Clinical Practice Recommendations
- Use the Diabetes Head to Toe Checklist Examination Report
- Advise on diet, exercise, and willingness to participate in DSME if diagnosed with diabetes
- If patient agrees to participate, proceed with referral



PARTNER

REFERRAL

- Use the Diabetes Self-Management Education and Support (DSME/S) for Adults with Type 2 Diabetes: Algorithm of Care to assess, provide and adjust for referral appropriately
- Complete and submit referral form to DSME provider via fax, email, or Health Information Exchange



FOLLOW UP

- Contact patient and troubleshoot issues with enrollment or participation in DSME



Point-of-Care: Diabetes Identification

(Excerpts from the abridged version of the American Diabetes Association Position Statement: **The Standards of Medical Care in Diabetes--2024**)

[https://diabetesjournals.org/care/article/47/Supplement_1/S11/153937/1-Improving-Care-and-Promoting-Health-in?](https://diabetesjournals.org/care/article/47/Supplement_1/S11/153937/1-Improving-Care-and-Promoting-Health-in?fulltext=true)

Criteria for the Diagnosis of Prediabetes and Diabetes

Diabetes may be diagnosed based on A1C criteria or plasma glucose criteria, either the fasting plasma glucose (FPG) or the 2-h plasma glucose (2-h PG) value after a 75-g oral glucose tolerance test (OGTT). The same tests are used to both screen for and diagnose diabetes. Diabetes may be identified anywhere along the spectrum of clinical scenarios: in seemingly low-risk individuals who happen to have glucose testing, in symptomatic patients, and in higher-risk individuals whom the provider tests because of a suspicion of diabetes. The same tests will also detect individuals with prediabetes.

	Prediabetes	Diabetes
A1C	5.7-6.4% (39-47 mmol/mol) OR	≥6.5%
FPG	100–125 mg/dL (5.6–6.9 mmol/L IFG) OR	≥126 mg/dL (7.0 mmol/L)
OGTT	140–199 mg/dL (5.6–6.9 mmol/L) OR	≥200 mg/dL (11.1 mmol/L)*
RPG		≥200 mg/dL (11.1 mmol/L)†

* In the absence of unequivocal hyperglycemia, results should be confirmed by repeat testing.
† Only diagnostic in a patient with classic symptoms of hyperglycemia or hyperglycemic crisis. RPG, random plasma glucose.

Criteria for Testing for Diabetes or Prediabetes in Asymptomatic Adults¹¹

- Testing should be considered in overweight or obese (BMI ≥25kg/m² or ≥kg/m² in Asian Americans) adults who have one or more of the following risk factors:
 - First-degree relative with diabetes
 - High-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander)
 - History of CVD
 - Hypertension (≥140/90 mmHg or on therapy for hypertension)
 - HDL cholesterol level <35 mg/dL (0.90 mmol/L) and/or a triglyceride level >250 mg/dL (2.82 mmol/L)
 - Women with polycystic ovary syndrome
 - Physical inactivity
 - Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans)
- Patients with prediabetes (A1c ≥5.7%, (39 mmol/mol), IGT, or IFG should be tested yearly.
- Women who delivered a baby weighing 9 lb or were diagnosed with GDM should have lifelong testing at least every 3 years.
- For all patients, particularly those who are overweight or obese, testing should begin at age 45 years.
- If results are normal, testing should be repeated at a minimum of 3-year intervals, with consideration of more frequent testing depending on initial results and risk status.

11 https://diabetesjournals.org/care/article/46/Supplement_1/S10/148045/1-Improving-Care-and-Promoting-Health-in

Critical Times to Provide Diabetes Self-Management Education and Support (DSME/S)

There are 4 critical times to assess, provide, and adjust DSME/S: (1) with a new diagnosis of type 2 diabetes, (2) Annually for health maintenance and prevention of complications, (3) when new complicating factors influence self-management, and (4) when transitions in care occur. Included below are the DSME/S Algorithm of Care and Algorithm: Action Steps. See, Powers et al, (2017, Jan 24). 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: *The Diabetes Educator OnlineFirst*, Volume 43, 1; for the complete guidance.

<https://journals.sagepub.com/toc/tdeb/current>

Diabetes Self-Management Education and Support for Adults with Type 2 Diabetes: Algorithm of Care

The diabetes education algorithm provides an evidence-based visual depiction of when to identify and refer individuals with type 2 diabetes to DSME/S. The algorithm defines 4 critical time points for delivery and key information on the self-management skills that are necessary at each of these critical times.



Four critical times to assess, provide, and adjust diabetes self-management education and support (DSME/S)			
1 At diagnosis	2 Annual assessment of education, nutrition, and emotional needs	3 When new complicating factors influence self-management	4 When transitions in care occur
When primary care provider or specialist should consider referral:			
<ul style="list-style-type: none"> Newly diagnosed. All newly diagnosed individuals with type 2 diabetes should receive DSME/S Ensure that both nutritional and emotional health are appropriately addressed in education or make separate referrals 	<ul style="list-style-type: none"> Needs review of knowledge, skills, and behaviors Long-standing diabetes with limited prior education Change in medication, activity, or nutritional intake HbA1c out of target Maintain positive health outcomes Unexplained hypoglycemia or hyperglycemia Planning pregnancy or pregnant For support to attain and sustain behavior change(s) Weight or other nutrition concerns New life situations and competing demands 	Change in: <ul style="list-style-type: none"> Health conditions such as renal disease and stroke, need for steroid or complicated medication regimen Physical limitations such as visual impairment, dexterity issues, movement restrictions Emotional factors such as anxiety and clinical depression Basic living needs such as access to food, financial limitations 	Changes in: <ul style="list-style-type: none"> Living situation such as inpatient or outpatient rehabilitation or now living alone Medical care team Insurance coverage that results in treatment change Age-related changes affecting cognition, self-care, etc.

Diabetes Self-Management Education and Support Algorithm: Action Steps

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

At diagnosis	Annual assessment of education, nutrition, and emotional needs	When new complicating factors influence	When transitions in care occur
Primary care provider/endocrinologist/clinical care areas of focus and action steps			
<ul style="list-style-type: none"> • Answer questions and provide emotional support regarding diagnosis • Provide overview of treatment and treatment goals • 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 • Make a referral for DSME/S and MNT 	<ul style="list-style-type: none"> • Assess all areas of self-management • Review problem-solving skills • Identify strengths and challenges of living with diabetes 	<ul style="list-style-type: none"> • Identify presence of factors that affect diabetes self-management and attain treatment and behavioral goals • Discuss effect of complications and successes with treatment and self-management 	<ul style="list-style-type: none"> • Develop diabetes transition plan • Communicate transition plan to new health care team members • Establish DSME/S regular follow-up care
Diabetes education: areas of focus and action steps *			
<p>Assess cultural influences, health beliefs, current knowledge, physical limitations, family support, financial status, medical history, literacy, numeracy to determine content to provide and how:</p> <ul style="list-style-type: none"> • Medications-choices, action, titration, side effects • Monitoring blood glucose -when to test, 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 • Developing personal strategies to address psychosocial issues and concerns • Developing personal strategies to promote health and behavior change 	<ul style="list-style-type: none"> • Review and reinforce treatment goals and self-management needs • Emphasize preventing complications and promotion quality of life • Discuss how to adapt diabetes treatment and self-management to new life situations and competing demands • Support efforts to sustain initial behavior changes and cope with the ongoing burden of diabetes 	<ul style="list-style-type: none"> • Provide support for the provision of self-care 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), adapting to new self-management demands, and promote health and behavior change 	<ul style="list-style-type: none"> • Identify needed adaptations in diabetes self-management • 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 beliefs, and feeling of well-being • Maximize quality of life and emotional support for the patient (and family members) • Provide education for others now involved in care • Establish communication and follow-up plans with the provider, family and others

* Educational content listed in each box is not intended to be all-inclusive, as specific needs will depend on the patient; however, these topics can guide the educational assessment and plan. <https://www.aafp.org/family-physician/patient-care/clinical-recommendations/all-clinical-recommendations/diabetes-screening-adults.html>

Diabetes Self-Management in Nevada

To refer your patients for Diabetes Self-Management Education, please visit the **Nevada Quality and Technical Assistance Center**: <https://www.nvqtac.org/> to view a listing of class schedules. The accompanying Diabetes Self-Management Education/Training and Medical Nutrition Therapy Services Order Form (Page 20) was designed by the Association of Diabetes Care & Education Specialists for companies to make referrals to Diabetes Self-Management Education Programs. For private insurance companies consult each payer's DSME/T and MNT policies for specific requirements.



Diabetes Education Providers/Programs

The Association of Diabetes Care & Education Specialists list accredited diabetes education programs in Nevada: Find diabetes programs:

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

The American Diabetes Association lists accredited diabetes education programs in Nevada: Find diabetes programs by typing in your zip code: <https://diabetes.org/tools-support/diabetes-education-program>

Nevada Quality and Technical Assistance Center

Call the Nevada QTAC: **702-616-4914** to be referred to Stanford and/or other diabetes self-management programs and classes. Visit: <https://www.nvqtac.org/>

The **Southern Nevada Health District** includes a list of free and low cost diabetes workshops and classes on their website: <https://gethealthyclarkcounty.org/manage-your-risk/diabetes/>

Diabetes class interest form: <https://gethealthyclarkcounty.org/manage-your-risk/diabetes-form/>



Additional Diabetes Resources

The **Nevada Diabetes Resource Directory**, updated by the **Nevada Diabetes Association**, includes statewide support groups and resources: <https://diabetesnv.org/resources-information/resource-directory/> (ENG/SP)

Community diabetes self-management classes, low cost clinics, and tobacco resources: <https://gethealthyclarkcounty.org/community-tools/healthcare/>

Chronic Disease and Tobacco Resources for Health Care Providers: Prescribe healthy lifestyle programs, apps and resources developed by the **Southern Nevada Health District:** <https://gethealthyclarkcounty.org/community-tools/healthcare/>

5210 Obesity Resources: Prescribe healthy lifestyle programs, apps and resources developed by the Southern Nevada Health District: <https://gethealthyclarkcounty.org/manage-your-risk/obesity/>

CDC DSMES Toolkit: <https://www.cdc.gov/diabetes/dsmes-toolkit/index.html>

Diabetes 2021 CDC Report Card: <https://www.cdc.gov/diabetes/library/reports/reportcard.html>

National Diabetes Statistics Report: <https://www.cdc.gov/diabetes/data/statistics/statistics-report.html>

Healthy Southern Nevada: Find diabetes and other data : www.healthysouthernnevada.org/

Health Insurance Coverage Laws for DSME Training: <http://www.ncsl.org/research/health/diabetes-health-coverage-state-laws-and-programs.aspx#>

ORDER FORM

Diabetes Self-Management Education & Support/Training & Medical Nutrition Therapy Services

MEDICARE COVERAGE: Diabetes self-management education and support/training (DSMES/T) and medical nutrition therapy (MNT) are separate and complementary services to improve diabetes self-care. Individuals may be eligible for both services in the same year. Research indicates MNT combined with DSMES/T improves outcomes.

DSMES/T: 10 hours initial DSMES/T in 12-month period from the date of first session with written referral from the treating qualified provider, plus 2 hours follow-up per calendar year.

MNT: 3 hrs initial MNT in the first calendar year, plus 2 hours follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis with a written referral from the treating physician.

Medicare coverage of DSMES/T and MNT requires the treating qualified provider to provide documentation of a diagnosis of diabetes based on **one of the following:**

- fasting blood glucose greater than or equal to 126 mg/dl on two different occasions
- 2 hour post-glucose challenge greater than or equal to 200 mg/dl on 2 different occasions
- random glucose test over 200 mg/dl for a person with symptoms of uncontrolled diabetes

*Other payors may have other coverage requirements. (Source: Volume 68, #216, November 7, 2003, page 63261/Federal Register)

PATIENT INFORMATION

Last Name _____			First Name _____			Middle _____			
Date of Birth ____/____/____			Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> _____						
Address _____			City _____			State _____		Zip Code _____	
Home Phone _____			Cell Phone _____			Email address _____			

DIAGNOSIS

Please send recent labs that support diagnostic criteria for patient eligibility & outcomes monitoring

Type 1 Type 2 Gestational Diagnosis code _____

Diabetes Self-Management Education & Support /Training (DSMES/T)

Check type of training services and number of hours requested

Initial DSMES/T 10 or ____ hours

Follow-up DSMES/T 2 hours

If more than 1 hour (1:1) for initial training please check special needs that apply:

- Vision Physical
- Hearing Social distancing during pandemic
- Language
- Cognitive Other (specify) _____

All DSMES/T content areas OR

Specific Content areas (Check all that apply)

- Monitoring diabetes
- Psychological adjustment
- Nutritional management
- Medications
- Diabetes as disease process
- Physical activity
- Goal setting, problem solving
- Prevent, detect and treat acute complications
- Prevent, detect and treat chronic complications
- Preconception, pregnancy, gestational diabetes
- Device Training

Medical Nutrition Therapy (MNT)

Check the type of MNT requested

Initial MNT 3 hours

Additional MNT hours for change in:

Annual follow-up MNT 2 hours

medical condition treatment diagnosis.

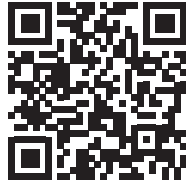
Signature and NPI # _____ Date ____/____/____

Group/practice name, address and phone: _____

FREE RESOURCES FOR SELF-MANAGEMENT AND CHRONIC DISEASE PREVENTION

We offer free online programs and mobile apps to help you prevent and manage chronic disease.

Learn more at
[GetHealthyClarkCounty.org](https://www.gethealthyclarkcounty.org)



DIABETES



ONLINE PROGRAM: The Road to Diabetes Prevention can help you

reduce the risk of developing type 2 diabetes.

Learn about your risk factors and how to make simple lifestyle changes to improve your health. **Sign up at**
[GetHealthyClarkCounty.org/Manage-Your-Risk/Diabetes](https://www.gethealthyclarkcounty.org/Manage-Your-Risk/Diabetes)



CLASSES: We offer free diabetes self-management education and support classes in-person or virtually.

Register for classes at

[GetHealthyClarkCounty.org/Manage-Your-Risk/Diabetes](https://www.gethealthyclarkcounty.org/Manage-Your-Risk/Diabetes)

HEART HEALTH



COMMUNITY PROGRAMS & CLASSES:

Do you know your numbers? Our online resources and education tools can help you learn how to manage your blood pressure to lower your risk for developing heart disease and stroke. Take charge of your health by taking steps to be more physically active, eat healthier, stop using tobacco products and monitor your blood pressure regularly. The **Barber/Beauty Shop Health Outreach Project (BSHOP/BeSHOP)** offers free blood pressure screenings at participating barber and beauty shops.

Find where you can get your blood pressure checked for free:

[GetHealthyClarkCounty.org/Community-Calendar](https://www.gethealthyclarkcounty.org/Community-Calendar)

Learn how to manage your risk and achieve a healthy lifestyle:

[GetHealthyClarkCounty.org/Manage-Your-Risk](https://www.gethealthyclarkcounty.org/Manage-Your-Risk)



NUTRITION



ONLINE PROGRAM: The Nutrition Challenge

is an eight-week online program that helps you increase your fruit and vegetable intake. Learn about how many fruits and vegetables you should eat and get weekly recipes. **Learn more at** [GetHealthyClarkCounty.org/Eat-Better](https://www.gethealthyclarkcounty.org/Eat-Better)



MOBILE APPS: Half My Plate is a mobile app

that helps you reach your goals for a healthy diet by inspiring you to make half your plate fruits and vegetables. The **SNAP Cooking** app features hundreds of easy recipes right at your fingertips. **Download at**

[GetHealthyClarkCounty.org/Eat-Better](https://www.gethealthyclarkcounty.org/Eat-Better)



PHYSICAL ACTIVITY



ONLINE PROGRAMS & MOBILE APPS:

The **Walk Around Nevada** online program and app help you reach your goals by tracking your daily physical activity.



The **Neon to Nature** online program and app provide trail listings that include trail information and photos, along with detailed map descriptions of the trail's location, length, and various amenities.



Find more tips at [GetHealthyClarkCounty.org/Get-Moving](https://www.gethealthyclarkcounty.org/Get-Moving)

TOBACCO USE



PHONE, TEXT, CHAT & ONLINE SUPPORT:

The **Nevada Tobacco Quitline** is a FREE and CONFIDENTIAL phone and web-based service available to Nevada residents 13 years of age or older looking to quit smoking and/or vaping. The Quitline provides one-on-one coaching and nicotine replacement therapy (patches, gum, or lozenges) for qualified individuals. Expert coaches help overcome common barriers such as dealing with stress, fighting cravings, coping with irritability, and controlling weight gain. Services are offered in many languages.



Call **1-800-QUIT-NOW (1-800-784-8669)** or text **QUITNOW** to **333888**. Learn more at [NevadaTobaccoQuitline.com](https://www.NevadaTobaccoQuitline.com)

RECURSOS PARA LA PREVENCIÓN DE ENFERMEDADES CRÓNICAS

Nosotros ofrecemos programas en línea gratuitos y aplicaciones móviles para ayudarle a reducir los factores de riesgo de enfermedades crónicas. **Aprenda más en nuestro sitio web: vivasaludable.org**

Algunos de los programas en línea y aplicaciones están disponible en Español.



DIABETES



PROGRAMA EN LÍNEA: El Camino a la Prevención de la Diabetes es un programa en línea para ayudar a reducir el riesgo de



desarrollar diabetes tipo 2. Aprenda sobre sus factores de riesgo y cómo hacer cambios simples en su estilo de vida para mejorar su salud. **Regístrese en VivaSaludable.org/Manage-Your-Risk/Diabetes**



CLASES: Ofrecemos clases gratuitas para el autocontrol de la diabetes en persona y virtuales. **Inscríbese para la próxima clase en VivaSaludable.org/Manage-Your-Risk/Diabetes**

SALUD DEL CORAZÓN



PROGRAMAS COMUNITARIOS Y CLASES: ¿Conoce sus números? Nuestra herramienta de recursos y educación puede ayudarle a conocer cómo manejar su presión arterial para disminuir su riesgo de desarrollar una enfermedad cardíaca o un derrame. Tome cargo de su salud tomando pasos para ser más físicamente activo, comer más saludable, dejar de utilizar productos de tabaco y para monitorear su presión arterial de manera regular. El proyecto **Barber/Beauty Shop Health Outreach (BSHOP/BeSHOP, por sus siglas en inglés)** ofrece eventos de revisión de la presión arterial.



Conozca dónde revisar su presión arterial gratis en: VivaSaludable.org/Community-Calendar

Para más información sobre cómo manejar su riesgo, y consejos sobre cómo lograr un estilo de vida saludable visite: VivaSaludable.org/Manage-Your-Risk

NUTRICIÓN



PROGRAMA EN LÍNEA: El Reto de Nutrición

es un programa en línea de ocho semanas que le ayuda a aumentar su consumo de frutas y verduras.

Conozca cuántas frutas y verduras debe comer y obtenga recetas semanales. **Aprenda más en VivaSaludable.org/Eat-Better**



APLICACIONES MÓVILES: La Mitad de Mi Plato es un aplicación que le ayuda a alcanzar sus metas para una

dieta saludable inspirándolo a llenar la mitad de su plato con frutas y verduras. La aplicación **Cocinando con SNAP** cuenta con cientos de recetas fáciles y de bajo costo justo al alcance de su mano. **Descargar en VivaSaludable.org/Eat-Better**



ACTIVIDAD FÍSICA



PROGRAMAS EN LÍNEA Y

APLICACIONES MÓVILES: El programa

en línea y aplicación **Caminando Alrededor de Nevada** está diseñado para ayudarle a lograr sus metas de actividad física al rastrear sus actividad física diarias. El programa y aplicación **Neón a la Naturaleza** proporciona un listado de senderos que incluyen información de los caminos y fotos, así como descripciones detalladas de mapas con las ubicaciones de los senderos, su longitud y varias amenidades.

Encuentre consejos adicionales en VivaSaludable.org/Get-Moving



USO DEL TABACO



APOYO POR TELÉFONO, TEXTO Y POR INTERNET:

La línea de ayuda para dejar de fumar de Nevada



es un servicio gratuito basado en el teléfono, disponible para los residentes de Nevada de 13 años o más que quieran dejar de fumar y/o vapear. La línea de ayuda proporciona una terapia de reemplazo de nicotina y consejería individual (parches, goma de mascar o pastillas) para individuos calificados. Los entrenadores expertos ayudan a superar las barreras comunes, como lidiar con el estrés, luchar contra los antojos, lidiar con la irritabilidad y controlar el aumento de peso. Los servicios se ofrecen en muchos idiomas. **Llame al 1-855-DEJELO-YA (1-855-335-3569) o envíe el mensaje de texto DEJELOYA al 333888. Aprenda más en NevadatobaccoQuitline.com**



Contáctenos en vivasaludable@snhd.org o 702-759-1270

FREE CLASS



MANAGE YOUR DIABETES



AVAILABLE
ONLINE OR
IN PERSON

Classes are taught by Health Educators who are trained facilitators in the Conversation Map® Diabetes Self-Management & Education curriculum.



LEARN MORE

-  (702) 759-1270
-  gethealthy@snhd.org
-  gethealthyclarkcounty.org/myd



SCAN THIS CODE
TO SIGN UP

*If at least 2 participants do not register,
classes will be rescheduled.*

www.gethealthyclarkcounty.org
GET MOVING. EAT BETTER. LIVE TOBACCO-FREE.

SNHD
Southern Nevada Health District



*The American Diabetes Association Recognizes this education service as meeting the National Standards for Diabetes Self-Management Education and Support.

Take Control of Diabetes

Free diabetes prevention and self-management programs are available through the Southern Nevada Health District and our community partners. Sign up today to take control of diabetes in your life!



DIABETES SELF-MANAGEMENT CLASSES

Southern Nevada Health District
(702) 759-1270 | gethealthy@snhd.org
gethealthyclarkcounty.org

Free diabetes classes are available using the US Diabetes Conversation Maps. Classes include healthy eating and physical activity materials and resources to help you live healthier with diabetes.

Dignity Health / Nevada Quality & Technical Assistance Center
(702) 616-4914 | (702) 616-4932
nvqtac.org

Free programs available in English and Spanish; Stanford curriculum. 6 sessions.

Healthy Living Institute at UMC
(702) 383-7353 (SELF)
umcsn.com/healthy-living-institute

Free and low-cost community classes, several topics, including diabetes.

Nevada Diabetes Association
1-800-379-3839 | diabetesnv.org

Visit the statewide resource directory for information about kids and family camps, support groups, classes, and resources.

DIABETES PREVENTION CLASSES

The Road to Diabetes Prevention Program
[gethealthyclarkcounty.org/](http://gethealthyclarkcounty.org/manage-your-risk/diabetes)
manage-your-risk/diabetes

is a free online program developed by the Southern Nevada Health District. Participate at your own pace. The program includes healthy eating and physical activity tips and resources to help you live healthier.

Dignity Health / Nevada Quality & Technical Assistance Center
(702) 616-4914 | (702) 616-4975
nvqtac.org

Find a listing of **CDC-recognized Diabetes Prevention Programs** near you: **dprp.cdc.gov/Registry**

**Southern Nevada Community Health Center
(702) 759-1700 | snchc.org**

Primary Care and Family Planning

Las Vegas: 280 S. Decatur Blvd.

Las Vegas: 2830 E. Fremont St.

**Community Outreach Medical Center
(702) 657-3873**

communityoutreachmedicalcenter.org

Las Vegas: 1090 E. Desert Inn Rd., Ste. 200

**First Person Care Clinic
(702) 380-8118 | firstpersoncc.org**

Las Vegas: 1200 S. 4th St., Ste. 111

Dental Clinic: 1200 S. 4th St., Ste 109

Las Vegas: 916 W Owens

Henderson: 200 E. Horizon Dr., Ste. A-B

**FirstMed Health & Wellness Centers
702-731-0909 | fmhwc.org**

Las Vegas: 400 Shadow Ln., Ste. 104

Las Vegas: 3343 S Eastern Ave.

N. Las Vegas: 3940 N. Martin Luther King Blvd., Ste. 105B

**Hope Christian Health Center
(702) 644-4673 (HOPE) | hopehealthvegas.org**

N. Las Vegas: 4357 Corporate Center Dr., Ste. 450

N. Las Vegas: 4040 N. Martin Luther King Blvd., Ste. A

**Nevada Health Centers
1-800-787-2568
nevadahealthcenters.org**

Cambridge Family Health Center
3900 Cambridge St., Ste. 102

Eastern Family Medical and Dental
2212 S. Eastern Ave.

Dental appointments call (702) 597-3898

Henderson Family Health Center
98 E. Lake Mead Pkwy., Ste. 103

Martin Luther King Family Health
1799 Mt. Mariah Dr.
Walk-in appointments may be available

CP Squires School Based Health Center
1312 E Tonopah Ave.

North Las Vegas Family Health
2225 Civic Center Dr., Ste. 224

**R.E.A.C.H. Your Community Health Center
(702) 703-1163 | reachlv.org**

Las Vegas: 823 Las Vegas Blvd. S., Ste. 500



Low-cost Clinics

Low-cost treatment of diabetes and other health care services are available through the Southern Nevada Community Health Center and our community partners.

Please call first to determine eligibility.

**Silver State Health Services
(702) 471-0420 | silverstatehealth.org**

Behavioral Health, Primary Care, and Student Services

Las Vegas: 2965 S Jones Blvd.

**Volunteers in Medicine of Southern Nevada
(702) 967-0530 | vmsn.org**

Free clinics. Call for appointment, no walk-ins.

Paradise Park Clinic
4770 Harrison Dr.

Ruffin Family Clinic
1240 N. Martin Luther King Blvd.

www.gethealthyclarkcounty.org
GET MOVING. EAT BETTER. LIVE TOBACCO-FREE.



CLASES GRATUITAS



CONTROLAR SU DIABETES



DISPONIBLE EN LÍNEA
O EN PERSONA

Las clases son impartidas por educadores de salud que son facilitadores capacitados en el plan de estudios de educación y autocontrol de la diabetes del mapa de conversaciones.



CONOZCA MÁS

 (702) 759-1270

 vivasaludable@snhd.org

 vivasaludable.org/csd



ESCANEE ESTE CÓDIGO PARA
SUSCRIBIRSE A NUESTRA LISTA
DE INTERESADOS



www.vivasaludable.org



*La Asociación Americana de la Diabetes reconoce que este Programa de Educación cumplió con los Estándares Nacionales de Educación y Apoyo para el cuidado personal de la diabetes.

Tome el Control de la diabetes

Hay programas gratuitos de prevención y automanejo de la diabetes disponibles por medio del Distrito de Salud del Sur de Nevada y nuestros socios comunitarios. ¡Inscríbese hoy mismo para tomar el control de la diabetes en su vida!



CLASES DE AUTOMANEJO DE LA DIABETES

Distrito de Salud del Sur de Nevada
(702) 759-1270 | vivasaludable@snhd.org
vivasaludable.org

Hay clases gratuitas de diabetes disponibles utilizando los Mapas de Conversación de la Diabetes de los Estados Unidos. Las clases incluyen materiales y recursos sobre alimentación saludable y actividad física para ayudarle a vivir de una manera más saludable con la diabetes.

Dignity Health / Centro de Asistencia Técnica y Calidad de Nevada
(702) 616-4914 | (702) 616-4932
nvqtac.org

Programas gratuitos disponibles en inglés y en español; currículo de Stanford. Seis sesiones.

Instituto de Vida Saludable Healthy Living en UMC
(702) 383-7353 (SELF)

umcsn.com/healthy-living-institute

Clases comunitarias gratuitas y a bajo costo, varios temas, incluyendo la diabetes.

Asociación de Diabetes de Nevada
1-800-379-3839 | diabetesnv.org

Visite el directorio de recursos estatales para obtener información sobre campamentos para niños y familias, grupos de apoyo, clases, y recursos.

CLASES DE PREVENCIÓN DE LA DIABETES

El Programa del Camino a la Prevención de la Diabetes

vivasaludable.org/training/diabetes

es un programa gratuito en línea desarrollado por el Distrito de Salud del Sur de Nevada. Participe a su propio ritmo. El programa incluye consejos y recursos sobre alimentación saludable y actividad física para ayudarle a vivir de una manera más saludable.

Dignity Health / Centro de Asistencia Técnica y Calidad de Nevada
(702) 616-4914 | (702) 616-4975
nvqtac.org

Encuentre un listado de **los programas de prevención de la diabetes** reconocidos por los Centros para el Control y Prevención de Enfermedades (CDC, por sus siglas en inglés) cerca de usted: **dprp.cdc.gov/Registry**



**Centro de Salud Comunitario del Sur de Nevada
(702) 759-1700 | snhc.org**

Cuidado primario y planificación familiar

Las Vegas: 280 S. Decatur Blvd.

Las Vegas: 2830 E. Fremont St.

**Centro Médico de Enlace Comunitario
(702) 657-3873**

communityoutreachmedicalcenter.org

Las Vegas: 1090 E. Desert Inn Rd., Ste. 200

**Clínica de Cuidado First Person Care Clinic
(702) 380-8118 | firstpersoncc.org**

Las Vegas: 1200 S. 4th St., Ste. 111

Clínica dental: 1200 S. 4th St., Ste 109

Las Vegas: 916 W Owens

Henderson: 200 E. Horizon Dr., Ste. A-B

**Centros de Salud y Bienestar
FirstMed Health & Wellness Centers
702-731-0909 | fmhwc.org**

Las Vegas: 400 Shadow Ln., Ste. 104

Las Vegas: 3343 S Eastern Ave.

N. Las Vegas: 3940 N. Martin Luther King Blvd., Ste. 105B

**Centro de Salud Hope Christian Health Clinic
(702) 644-4673 (HOPE) | hopehealthvegas.org**

N. Las Vegas: 4357 Corporate Center Dr., Ste. 450

N. Las Vegas: 4040 N. Martin Luther King Blvd., Ste. A

**Centros de Salud de Nevada
1-800-787-2568
nevadahealthcenters.org**

Centro de Salud Cambridge

3900 Cambridge St., Ste. 102

Centro Medico y Dental de Salud Familiar - Eastern

2212 S. Eastern Ave.

Llame para citas con el dentista (702) 597-3898

Centro de Salud Familiar - Henderson

98 E. Lake Mead Pkwy., Ste. 103

Salud Familiar - Martin Luther King

1799 Mt. Mariah Dr.

Pueden estar disponibles visitas sin cita previa

Centro de Salud CP Squires School Based Health Center

1312 E Tonopah Ave.

Salud Familiar - North Las Vegas

2225 Civic Center Dr., Ste. 224

**R.E.A.C.H. Tu Centro Comunitario de Salud
(702) 703-1163 | reachlv.org**

Las Vegas: 823 Las Vegas Blvd. S., Ste. 500



Clinicas de bajo costo

Hay **tratamiento de diabetes** a bajo costo y otros servicios de cuidado de la salud disponibles por medio del Centro de Salud Comunitaria del Sur de Nevada (Southern Nevada Community Health Center) y nuestros socios comunitarios.

Por favor llamar antes para determinar la elegibilidad.

**Silver State Health Services
(702) 471-0420 | silverstatehealth.org**

Salud de comportamiento, cuidado primario y servicios estudiantiles

Las Vegas: 2965 S Jones Blvd.

**Voluntarios en Medicina del Sur de Nevada
(702) 967-0530 | vmsn.org**

Clínicas gratuitas. Llamar para hacer una cita, no se reciben pacientes sin cita previa.

Clinica Paradise Park

4770 Harrison Dr.

Clinica Ruffin Family

1240 N. Martin Luther King Blvd.



BMI calculation chart

WEIGHT	100	110	120	130	140	150	160	170	180	190	200	210	220	230	240	250	260	270	280	290	300	310	320	330	340	350	360	370	380	390	400
5'0"	19	21	23	25	27	29	31	33	35	37	39	41	43	45	47	49	51	53	55	57	59	61	63	65	67	69	71	72	74	76	78
5'1"	18	20	22	24	26	28	30	32	34	36	37	39	42	44	45	47	49	51	53	55	57	59	61	63	64	66	68	70	72	74	76
5'2"	18	20	22	23	25	27	29	31	33	34	36	38	40	42	44	46	48	50	51	53	55	57	59	61	62	64	66	68	70	72	73
5'3"	17	19	21	23	24	26	28	30	32	33	35	37	39	41	43	44	46	48	50	52	53	55	57	59	60	62	64	66	67	69	71
5'4"	17	18	20	22	24	25	27	29	31	32	34	36	38	40	41	43	45	46	48	50	52	53	55	57	59	60	62	64	65	67	69
5'5"	16	18	20	21	23	25	26	28	30	31	33	35	37	38	40	42	43	45	47	48	50	52	53	55	57	58	60	62	63	65	67
5'6"	16	17	19	21	22	24	25	27	29	30	32	34	36	37	39	40	42	44	45	47	49	50	52	53	55	57	58	60	62	63	65
5'7"	15	17	18	20	22	23	25	26	28	29	31	33	35	36	38	39	41	42	44	46	47	49	50	52	53	55	57	58	60	61	63
5'8"	15	16	18	19	21	22	24	25	27	28	30	32	34	35	37	38	40	41	43	44	46	47	49	50	52	53	55	56	58	59	61
5'9"	14	16	17	19	20	22	23	25	26	28	29	31	33	34	36	37	39	40	41	43	44	46	47	49	50	52	53	55	56	58	59
5'10"	14	15	17	18	20	21	23	24	25	27	28	30	32	33	35	36	37	39	40	42	43	45	46	47	49	50	52	53	55	56	58
5'11"	14	15	16	18	19	21	22	23	25	26	28	29	31	32	34	35	36	38	39	41	42	43	45	46	48	49	50	52	53	55	56
6'0"	13	14	16	17	19	20	21	23	24	25	27	28	30	31	33	34	35	37	38	39	41	42	44	45	46	48	49	50	52	53	54
6'1"	13	14	15	17	18	19	21	22	23	25	26	27	29	30	32	33	34	36	37	38	39	41	42	44	45	46	48	49	50	52	53
6'2"	12	14	15	16	18	19	20	21	23	24	25	27	28	30	31	32	33	34	36	37	38	39	40	41	42	44	45	46	48	49	50
6'3"	12	13	14	16	17	18	19	21	22	23	24	26	28	29	30	31	33	34	35	36	38	39	40	41	42	44	45	46	48	49	50
6'4"	12	13	14	15	17	18	19	20	21	23	24	26	27	28	29	31	32	33	34	35	37	38	39	40	41	43	44	45	46	48	49
6'5"	11	13	14	15	16	17	19	20	21	22	24	25	26	27	29	30	31	32	33	34	35	37	38	39	40	41	43	44	45	46	48

Blue Underweight: Less than 18.5

Green Healthy Weight: 18.5 - 24.9

Yellow Overweight: 25 - 29.9

Orange Obese: 30 - 39.9

Red

Extreme Obesity: 40 or greater

BMI stands for "BODY MASS INDEX" which is an estimate of total body fat based on height and weight. It is used to screen for weight categories that may lead to health problems.

THE GOAL for most people is to have a BMI in the green area. It is usually best for your BMI to stay the same over time or to gradually move toward the green area.

Codes: When screening for prediabetes and diabetes

Codes for prediabetes and diabetes screening			
International Classification of Diseases (ICD)-10 for diabetes screening		Current Procedural Terminology (CPT®) for diabetes screening tests	
Z13.1	Screening for diabetes mellitus	CPT 83036QW	Office-based Hemoglobin A1C
R73.09	Other Abnormal Glucose	CPT 82962	Hemoglobin A1C (office-based finger stick glucose testing)
R73.01	Impaired Fasting Glucose		
R73.02	Impaired Glucose Tolerance (oral)		
R73.9	Hyperglycemia, unspecified		
E66.8, E66.9	Other obesity, obesity unspecified		
E66.3	Overweight		

These codes may be useful to report services/tests performed to screen for prediabetes and diabetes.

Find updated codes and resources (AMA): <https://amapreventdiabetes.org/> and:

<https://amapreventdiabetes.org/tools-resources>

References

American Medical Association 2023, <https://amapreventdiabetes.org/>

Improving Care and Promoting Health in Populations: Standards of Care in Diabetes--2024

https://diabetesjournals.org/care/article/47/Supplement_1/S11/153937/1-Improving-Care-and-Promoting-Health-in?searchresult=1

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