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

This important guide is being made available to you by the Chronic Disease Prevention and Health Promotion Section of the Nevada Division of Public and Behavioral Health.
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. 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.

**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:

- 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.

*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.*

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
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Engage clinicians
Team Care Approach for Diabetes Management

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.

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 American Association of Diabetes Educator’s (AADE) 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

AADE7™ Self-Care Behaviors:

The AADE developed seven self-care behaviors (the AADE7) 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 dieticians, and pharmacists. Many of the health care professionals who provide DSME services through accredited programs also carry the designation Certified Diabetes Educator (CDE). In addition to certified DSME providers, 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 learn the skills to best self-manage their diabetes. While the clinician focuses on proving 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 (DSMT).

Benefits of Partnering Within a DSME Team Model

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<th>Increased efficiency for clinicians with DSME providers educating, training and following up with clients</th>
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How Do Diabetes Educators Help?

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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 for 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 http://www.chronicdisease.org/?page=DiabetesDSMEresource#Desired%20outcomes
9 http://www.chronicdisease.org/default.asp?page=DiabetesDSMEresource#National%20Standards%20for%20DSME/T
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. (AADE-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 codes is included in this guide on page 12.

**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 closely\(^{10}\)

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.

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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.

Add up your score.

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.

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

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.

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

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+

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

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

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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: 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 www.cdc.gov/diabetes/ndep.
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.

NevadaWellness.org  ■  NVDiabetesEd.org

Nevada Division of Public and Behavioral Health, Chronic Disease Prevention and Health Promotion

Supported by the Nevada State Division of Public and Behavioral Health through grant number 3U58DP004820-02W1 from the Centers for Disease Control and Prevention.
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 – 2015, 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: Standards of Medical Care in Diabetes—2015. Diabetes Care 2015;38(Suppl. 1): S1–S94.)

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.

<table>
<thead>
<tr>
<th>Prediabetes</th>
<th>Diabetes</th>
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<tr>
<td><strong>A1C</strong></td>
<td>≥6.5%</td>
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<tr>
<td>5.7–6.4%</td>
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<tr>
<td><strong>FPG</strong></td>
<td>≥126 mg/dL (7.0 mmol/L)</td>
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<tr>
<td>100–125 mg/dL (5.6–6.9 mmol/L)</td>
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<tr>
<td><strong>OGTT</strong></td>
<td>≥200 mg/dL (11.1 mmol/L)*</td>
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<tr>
<td>140–199 mg/dL (5.6–6.9 mmol/L)</td>
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</tr>
<tr>
<td><strong>RPG</strong></td>
<td>≥200 mg/dL (11.1 mmol/L)†</td>
</tr>
<tr>
<td>≥200 mg/dL (11.1 mmol/L)</td>
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*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 Adults

Testing to detect type 2 diabetes in asymptomatic people should be considered in adults of any age who are overweight or obese (BMI ≥25 kg/m² or ≥23 kg/m² in Asian Americans) and who have one or more additional risk factors for diabetes. For all patients, particularly those who are overweight or obese, testing should begin at age 45 years.

Testing should be considered in adults who are overweight (BMI ≥25 kg/m² or ≥23 kg/m² in Asian Americans) and have additional risk factors:

- Physical inactivity
- First-degree relative with diabetes
- High-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander)
- Women who delivered a baby weighing 9 lb or were diagnosed with GDM
- 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
- A1≥5.7%, IGT, or IFG on previous testing
- Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans)
- History of CVD

11 http://clinical.diabetesjournals.org/content/33/2/97.full.pdf+html
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, (2015, June 5). 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, 1-14; for the complete guidance.

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 time to assess, provide, and adjust diabetes self-management education and support (DSME/S)

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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td><strong>At diagnosis</strong></td>
<td><strong>Annual assessment of education, nutrition, and emotional needs</strong></td>
<td><strong>When new complication factors influence self-management</strong></td>
<td><strong>When transitions in care occur</strong></td>
</tr>
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</table>

**When primary care provider or specialist should consider referral:**

1. 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
2. Needs review of knowledge, skills, and behaviors
3. Long-standing diabetes with limited prior education
4. Change in medication, activity, or nutritional intake
5. HbA1c out of target
6. Maintain positive health outcomes
7. Unexplained hypoglycemia or hyperglycemia
8. Planning pregnancy or pregnant
9. For support to attain and sustain behavior change(s)
10. Weight or other nutrition concerns
11. New life situations and competing demands

**Change in:**

- 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:**

- 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

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<tr>
<th>Four critical times to assess, provide, and adjust diabetes self-management education and support</th>
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<tr>
<td><strong>At diagnosis</strong></td>
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<tr>
<td>• Answer questions and provide emotional support regarding diagnosis</td>
</tr>
<tr>
<td>• Provide overview of treatment and treatment goals</td>
</tr>
<tr>
<td>• Teach survival skills to address immediate requirements (safe use of medication, hypoglycemia treatment if needed, introduction of eating guidelines)</td>
</tr>
<tr>
<td>• Make referral for DSME/S and MNT</td>
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### Primary care provider/endocrinologist/clinical care team: areas of focus and action steps

- 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)
- Make referral for DSME/S and MNT

### Diabetes education: areas of focus and action steps *

- Assess cultural influences, health beliefs, current knowledge, physical limitations, family support, financial status, medical history, literacy, numeracy to determine content to provide and how:
  - 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

- 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

- 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

- 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.
Diabetes Self-Management in Nevada

To refer your patients for Diabetes Self-Management Education, please go to NVDiabetesED.org for more information and to find a diabetes educator in your area.

The accompanying Diabetes Self-Management Education/Training and Medical Nutrition Therapy Services Order Form (Page 19) was designed by the American Association of Diabetes Educators and American Dietetic Association to meet requirements set forth by Medicare and most insurance companies to make referrals for Diabetes Self-Management Education Programs. For private insurance companies consult each payer’s DSME/T and MNT policies for specific requirements.
# Diabetes Self-Management Education/Training and Medical Nutrition Therapy Services Order Form

## Patient Information

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<th>Patient’s Last Name</th>
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Diabetes self-management education and training (DSME/T) and medical nutrition therapy (MNT) are individual and complementary services to improve diabetes care. Both services can be ordered in the same year. Research indicates MNT combined with DSME/T improves outcomes.

## Diabetes Self-Management Education/Training (DSME/T)

**Check type of training services and number of hours requested**

- Initial group DSME/T: 10 hours or ___ no. hrs. requested
- Follow-up DSME/T: 2 hours or ___ no. hrs. requested
- Telehealth

**Patients with special needs requiring individual (1 on 1) DSME/T**

*Check all special needs that apply:*

- Vision
- Hearing
- Physical
- Cognitive Impairment
- Language Limitations
- Additional training
- Additional hrs requested ___
- Telehealth
- Other ___

**DSME/T Content**

- Monitoring diabetes
- Psychological adjustment
- Nutritional management
- Medications
- Preconception/pregnancy management or GDM
- Prevent, detect and treat chronic complications

**Medicare coverage:** 10 hrs initial DSMT in 12 month period from the date of first class or visit

**DIAGNOSIS**

*Please send recent labs for patient eligibility & outcomes monitoring*

- Type 1
- Type 2
- Gestational

**Complications/Comorbidities**

*Check all that apply:*

- Hypertension
- Dyslipidemia
- Stroke
- Neuropathy
- PVD
- Kidney disease
- Retinopathy
- CHD
- Non-healing wound
- Pregnancy
- Obesity
- Mental/affective disorder
- Other ___

**Medical Nutrition Therapy (MNT)**

**Check the type of MNT and/or number of additional hours requested**

- Initial MNT: 3 hours or ___ no. hrs. requested
- Annual follow-up MNT: 2 hours or ___ no. hrs. requested
- Telehealth
- Additional MNT services in the same calendar year, per RD

**Additional hrs. requested ___

*Please specify change in medical condition, treatment and/or diagnosis:*

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

**Definition of Diabetes (Medicare)**

Medicare coverage of DSMT and MNT requires the physician to provide documentation of a diagnosis of diabetes based on one of the following:

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


Other payors may have other coverage requirements.

**Signature and NPI #**

_____________________________________________________________________________________

**Date** MM/DD/YY

**Group/practice name, address and phone:**

________________________________________________________

### Diabetes Head to Toe Checklist Examination Report

**Your organization’s name here**

#### Patient Information:

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- **Diabetes:**
  - Type 1
  - Type 2
  - Gestational
  - Prediabetes

- **HbA1c Goal:**
  - < 6 months
  - ≥ 6 months
  - Unknown

- **Duration of Diabetes (in years):**

- **Current Diabetes Therapy:**
  - Insulin
  - Oral Hypoglycemic
  - Diet Control
  - None

- **Results of Last Finger-stick blood glucose reading (per patient):**

- **Dietary Counseling**

- **Other:**

- **Doctor’s Signature:**

#### Medicines

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<th>Date:</th>
<th>Patient has a written med list Yes</th>
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<td>OTC Meds Used: (if none: )</td>
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<td>Herbal Meds Used: (if none: )</td>
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<td>Pharmacist reviewed meds on (date):</td>
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<td>Patient has Rx for: (provide reason if “no”)</td>
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<td>Aspirin Yes</td>
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<td>Cholesterol med Yes</td>
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<td>ACE inh or ARB Yes</td>
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- **Reports Side Effects to Meds:**
  - Yes
  - No

- **Reports hypoglycemia events:**
  - Yes
  - No

- **Does patient know their current:**
  - A1c?
  - Yes
  - No Goal A1c?
  - Yes
  - No

- **LDL?**
  - Yes
  - No Goal LDL?
  - Yes
  - No

- **BP?**
  - Yes
  - No Goal BP?
  - Yes
  - No

- **Home Glucose Monitoring Frequency:**
  - Once daily
  - Twice daily
  - 3-4 times daily
  - Other: 

- **History of myocardial infarction, heart failure, or stroke:**

- **Heart or brain testing (e.g. stress test, echo, angiogram, CT scan, ultrasound, MRI):**

- **History of dialysis or kidney transplant:**

#### Kidney/Heart & Vascular

- **Follow-up:__________ months**

- **ACE inh or ARB**

- **Cholesterol med**

- **Patient has Rx for:** (provide reason if “no”)

- **Pharmacist reviewed meds on (date): ______**

- **Herbal Meds Used:** (if none: )

- **Patient has a written med list**

#### Mouth

- **Intraoral/Extraoral:**

- **Periodontal (health, abscesses, gingivitis, periodontitis):**

- **Functional (eating, swallowing, etc) concerns:**

- **Additional Testing/Treatment Recommended:**

- **Refer to Specialist:**

- **Re-evaluate in _______ months(s)**

#### FEET

- **Current ulcer or history of a foot ulcer:**
  - Yes
  - No

- **Foot Exam: Skin, Hair, and Nail Condition**

- **Note Musculoskeletal Deformities**

- **Intact protective sensation**

- **Pedal pulses present**

- **Posterior tibial**
  - Left__ Right__
  - Dorsalis pedis Left__Right__

- **Pedal Pulses:** - “P” for present or “A” for absent

- **Foot deformities**

- **Intact protective sensation**

- **Loss of protective sensation**

- **Absent pedal pulses**

- **Foot deformity**

- **No prior foot ulcer**

- **Prior amputation**

#### Eyes

- **Intraocular Pressure**

- **Dilated Fundus Exam Performed**

- **Diagnosis:**

- **No Diabetic Retinopathy**
  - Yes
  - No

- **Non-Proliferative Diabetic Retinopathy**
  - Yes
  - No

- **Clinically Significant Macular Edema**
  - Yes
  - No

#### Information pamphlet given

#### Management:

- **Follow-up:__________ months**

- **Patient education/discussion**

- **Information pamphlet given**

- **Referral To:**

- **Other:**

- **Doctor’s Signature**
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.

### BMI Chart

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**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
### Codes: When screening for prediabetes and diabetes

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<td>V77.1</td>
<td>Diabetes Screening</td>
<td>CPT 82947 Fasting Plasma Glucose Test</td>
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<td>CPT 82950 Post-meal Glucose (2-hour plasma glucose; 2hPG; 2 hr specimen)</td>
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<td>Impaired Fasting Glucose</td>
<td>CPT 82951 Oral Glucose Tolerance (3 specimens with 2 hr value included)</td>
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<td>Impaired Glucose Tolerance (oral)</td>
<td>CPT 83036 Hemoglobin A1C</td>
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<td>Other Abnormal Glucose NEC</td>
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<td>Overweight</td>
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</table>

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

References

‡ Ackermann RT. Coding Guide for Diabetes and Prediabetes Testing. 2013. (Published here with permission from Ronald T. Ackermann MD, MPH,)
The mission of Chronic Disease Prevention and Health Promotions is to maximize the health of Nevadans by improving policy, systems and environment that influence quality of life.