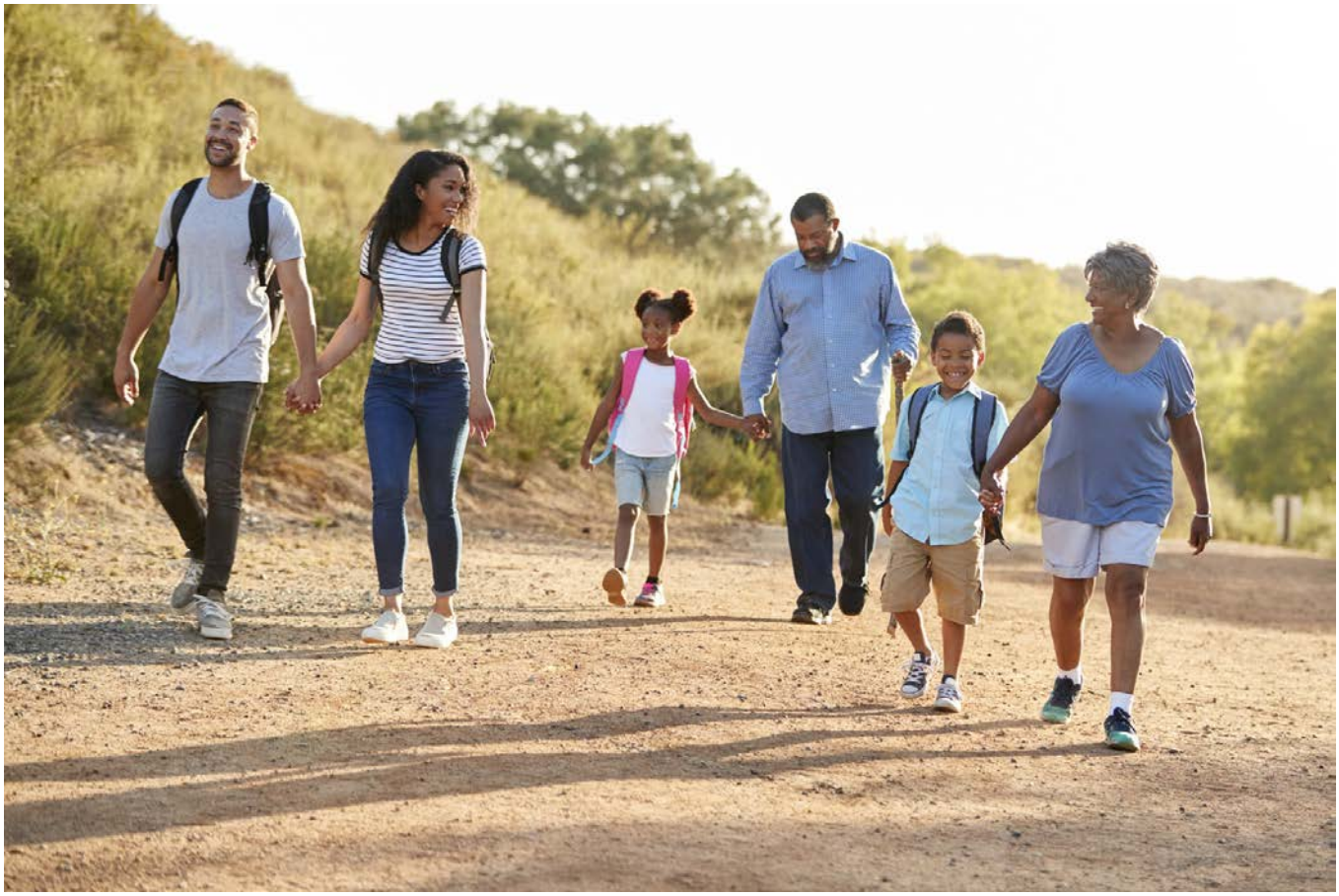

PREVENTING TYPE 2 DIABETES

A guide to refer your patients with prediabetes to an evidence-based diabetes prevention program

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AMA AMERICAN MEDICAL ASSOCIATION

Prevent Diabetes **STAT** | Screen / Test / Act Today™

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Preventing diabetes: Making a difference by linking the clinic with the community.

In the average primary care practice, it's likely that one-third of patients over age 18, and half over age 65, have prediabetes.

Use this guide to help your patients delay or prevent the onset of type 2 diabetes

Prediabetes is a health condition characterized by blood glucose levels that are higher than normal, but not high enough to be diagnosed as diabetes. Prediabetes increases the risk for type 2 diabetes, heart disease and stroke.

Prediabetes is treatable, but 90 percent of people with prediabetes don't know they have it. Left untreated up to one-third of people with prediabetes will progress to diabetes within five years.

During that window of time your patients can benefit from a proven lifestyle change intervention that is part of the National Diabetes Prevention Program (National DPP) led by the Centers for Disease Control and Prevention (CDC).

The United States Preventive Services Task Force (USPSTF) issued a Grade B recommendation in 2015 which states that all adults aged 40 to 70 years who are overweight or obese should be screened for type 2 diabetes mellitus. The recommendation also notes that physicians can consider screening younger adults or adults with normal weight if they have a family history of type 2 diabetes mellitus, a past medical history of gestational diabetes or polycystic ovarian syndrome, or if they are a member of a racial or ethnic minority. The USPSTF also recommends that all adults with abnormal glucose be referred to an intensive behavioral counseling intervention such as a CDC-recognized diabetes prevention program.

As part of the National DPP, the American Medical Association (AMA) and the CDC are collaborating to create tools and resources that care teams can use to identify patients with prediabetes, and refer eligible patients to in-person or online diabetes prevention programs.

Physicians and care teams from a diverse group of practices helped the AMA and the CDC create the tools in this guide, and have used them in their own practices to:

- Screen and identify patients for prediabetes
- Refer patients to diabetes prevention programs
- Create feedback loops, linking the patient's progress in the diabetes prevention program back to the practice

Part of a national movement

To achieve CDC recognition as part of the National DPP, programs must provide evidence they are following a CDC-approved curriculum and achieving meaningful results with patients. These programs are based on research showing that a year-long, structured lifestyle change intervention reduced the incidence of diabetes by 58 percent among adults with prediabetes and by 71 percent in those aged 60 years or older.

These programs are successful in part because they require only moderate weight loss to achieve preventive health benefit. A minimum 5 percent weight loss—10 pounds for a person weighing 200 pounds—led to the results mentioned above.

The AMA and the CDC are promoting these diabetes prevention programs because they are one of the most effective ways to help physicians prevent or delay type 2 diabetes in high-risk patients.

Use this implementation guide and its tools to help identify and refer patients with prediabetes to a diabetes prevention program that is part of the CDC's National DPP.

Overview of guide tools

Resource	Purpose
Engaging clinicians	
You can prevent type 2 diabetes Health care provider fact sheet	Provides a brief overview of the evidence-based diabetes prevention program and a rationale for engaging with the program, such as improved patient outcomes. Also assists clinicians in advocating to their colleagues and leaders about the value of incorporating diabetes prevention screening and referral into their practices.
Engaging patients	
Prediabetes risk test	Offers an educational opportunity for patients to learn about their risk for prediabetes, and help physicians and care teams identify their patients at great risk.
Promoting prediabetes awareness to your patients 8" x 11" poster	Helps practices increase patient awareness of prediabetes to pave the way for conversations with patients about screening and referral.
Are you at risk for type 2 diabetes? Patient handout	For use by physician practices in patient waiting areas to increase patient awareness and pave the way for conversations with patients about screening and referral.
So you have prediabetes… now what? Patient handout	For use by physician practices in the exam room after screening has revealed that a patient has prediabetes. Helps the patient leave the office visit with concrete information for later reference.
Incorporate screening, testing and referral into practice	
M.A.P. to diabetes prevention for your practice One-page overview	Offers practices a one-page roadmap to applying the elements of the diabetes prevention screening and referral guide.
Point-of-care prediabetes identification algorithm Infographic and narrative	With a graphic on one side, and narrative on other, the document offers practices an option to adapt/ incorporate a prediabetes screening and referral process into their workflow.
Retrospective prediabetes identification algorithm Infographic and narrative	With a graphic on one side, and narrative on other, the document offers practices an option to adapt/ incorporate an identification and referral process into their electronic health records and generate a registry of patients at risk for type 2 diabetes.
Sample "Patient letter/email and phone script"	Enables physician practices to conduct efficient follow-up and referral with patients who have been identified as having prediabetes, informing them of their prediabetes status and referral to an evidence-based diabetes prevention program.
Sample patient referral form/table for calculating body mass index	Makes the referral process easier for practices, helps engage the patient (particularly if they sign the optional patient signature box) and prepares diabetes prevention program providers to engage with the patient as well.
Commonly used CPT and ICD codes Table	Enables physician practices to obtain reimbursement for prediabetes screening.
Connect your clinic with diabetes prevention programs	
Link to sample "Business Associate Agreement" on AMA's website	Provides link to template agreement some practices have used to share information with diabetes prevention program providers.

Additional information

AMA diabetes prevention initiative
https://amapreventdiabetes.org/tools-resources
Learn more about the AMA's commitment to preventing type 2 diabetes and download free prediabetes fact sheets and risk tests, available in English and Spanish.

Centers for Disease Control and Prevention's National Diabetes Prevention Program
cdc.gov/diabetes/prevention
Visit this site for detailed information about the CDC's National Diabetes Prevention Program.

National Diabetes Education Program
ndep.nih.gov/am-i-at-risk/
Find educational resources about preventing diabetes for you and your patients.

How does a diabetes prevention program work?

Diabetes prevention programs that are part of the National DPP use lifestyle change interventions that target improving diet, increasing physical activity and achieving moderate weight loss.

The goal for each participant is to lose ≥5% of body weight by:

- Progressively reducing dietary intake of calories and fat through improved food choices
- Gradually increasing moderate physical activity (e.g., brisk walking) to ≥150 minutes per week
- Developing behavioral problem-solving and coping skills

Features include:

- A year-long structured program (in-person group, online or distance learning) consisting of:
  - An initial six-month phase offering at least 16 sessions over 16–24 weeks
  - A second six-month phase offering at least one session a month (at least six sessions)
- Facilitation by a trained lifestyle coach
- Use of a CDC-approved curriculum
- Regular opportunities for direct interaction between the lifestyle coach and participants
- An emphasis on behavior modification, managing stress and peer support

Who is eligible for referral to a diabetes prevention program?

To be eligible for referral, patients must:

- Be at least 18 years old **and**
- Be overweight (Body Mass Index (BMI) ≥24; ≥22 if Asian)* **and**
- Have a blood test result in the prediabetes range within the past year:
  - Hemoglobin A1C: 5.7–6.4% **or**
  - Fasting plasma glucose: 100–125 mg/dL **or**
  - Two-hour plasma glucose (after a 75 gm glucose load): 140–199 mg/dL **or**
- Been previously diagnosed with gestational diabetes and
- Have no previous diagnosis of diabetes

Physicians and other health care providers should also use their independent judgment when referring to a diabetes prevention program.

* These BMI levels reflect eligibility for the National DPP as noted in the CDC Diabetes Prevention Recognition Program Standards and Operating Procedures. The American Diabetes Association (ADA) encourages screening for diabetes at a BMI of ≥23 for Asian Americans and ≥25 for non-Asian Americans, and some programs may use the ADA screening criteria for program eligibility. Please check with your diabetes prevention program provider for their specific BMI eligibility requirements.

How can patients find a diabetes prevention program near them?
Diabetes prevention programs are available in varied locations such as local YMCAs, wellness centers, faith-based organizations and worksites—as well as in health care facilities. Online versions are also available. Visit https://dprp.cdc.gov/Registry or the Nevada Quality and Technical Assistance Center: https://www.dignityhealth.org/las-vegas/classes-and-events/diabetes-lifestyle-training-and-nutrition-services **702-616-4914** to find a program that is part of the CDC's National DPP recognition program.

Does health insurance cover patient participation in a diabetes prevention program?
A growing number of private health insurers offer coverage for patient participation in diabetes prevention programs. Several employers include coverage as part of workplace wellness programs. Costs for a full year of program participation are approximately $400–$500. Some program providers offer monthly payment plans and discounts based on ability to pay. The AMA and the CDC continue to advocate for public and private insurance coverage of the diabetes prevention program.

How do I code for prediabetes screening?
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.

Feedback from diabetes prevention program to referring clinicians

Most programs send reports of participant progress to referring clinicians after the eighth and 16th group sessions. In addition, participants in the program complete periodic self-evaluations that referring clinicians can request directly from patients.

Sending patient information to a diabetes prevention program provider

Business Associate Agreement
Under the U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA), a HIPAA Business Associate Agreement (BAA) is a contract that protects personal health information in accordance with HIPAA guidelines. Some physician practices may want to explore whether a BAA is needed to exchange information with a diabetes prevention program. (Link to a "Business Associates Agreement" template on AMA's website.)

Engaging clinicians





You can prevent type 2 diabetes

Test your patients for prediabetes and refer those at risk to an evidence-based diabetes prevention program

You likely know which of your patients is at high risk for type 2 diabetes. Until now you may not have had a resource to help them stop the progression from prediabetes to diabetes. Now, you do.

The American Medical Association and the Centers for Disease Control and Prevention (CDC) have created a toolkit that can help physician practices screen and refer patients to evidence-based diabetes prevention programs without adding a burden to your practice. Visit **https://amapreventdiabetes.org/** and **https://amapreventdiabetes.org/tools-resources** to learn more.

- Progression from prediabetes to diabetes can take as little as five years.
- During that window of time, your patients can benefit from a proven intervention that is part of the CDC's National Diabetes Prevention Program (National DPP).
- Counsel your patients that prediabetes is a potentially reversible condition, and one that you can help them manage effectively by:
  - Screening and identifying patients with prediabetes
  - Referring them to a program that is part of the CDC's National DPP

The United States Preventive Services Task Force (USPSTF) issued a Grade B recommendation in 2015 which states that all adults aged 40 to 70 years who are overweight or obese should be screened for type 2 diabetes mellitus. The recommendation also notes that physicians can consider screening younger adults or adults with normal weight if they have a family history of type 2 diabetes mellitus, a past medical history of gestational diabetes or polycystic ovarian syndrome, or if they are a member of a racial or ethnic minority. The USPSTF also recommends that all adults with abnormal glucose be referred to an intensive behavioral counseling intervention such as a CDC-recognized diabetes prevention program.

This program is evidence-based

- The diabetes prevention program is a lifestyle intervention based on research funded by the National Institutes of Health that showed, among those with prediabetes, a 58 percent reduction in the number of new cases of diabetes overall, and a 71 percent reduction in new cases for those over age 60.
- These results were achieved through reducing calories, increasing physical activity, and a weight loss of just a minimum 5 percent weight loss—10 pounds for a person weighing 200 pounds.*
- Based on strong evidence of effectiveness in reducing new-onset diabetes, the Community Preventive Services Task Force (https://www.thecommunityguide.org/) now recommends combined diet and physical activity promotion programs like the National DPP, for people at increased risk of type 2 diabetes.

See next page to determine which of your patients is eligible for the diabetes prevention program.

In the average primary care practice it's likely one-third of patients over age 18, and half over age 65, have prediabetes.

* Visit **https://www.niddk.nih.gov/about-niddk/research-areas/diabetes/diabetes-prevention-program-dpp** to learn more about this research.





Program overview

- The program empowers patients with prediabetes to take charge of their health and well-being.
- Participants meet in groups with a trained lifestyle coach for 16 weekly sessions and 6–8 monthly follow-up sessions.
- These are NOT exercise classes. At these sessions patients learn ways to incorporate healthier eating and moderate physical activity, as well as problem-solving, stress-reduction and coping skills into their daily lives.

Locating a program

- Programs are offered in varied locations such as local YMCAs, community centers, faith-based organizations, hospitals and worksites, and are also available online.
- Find a program for your patients at **https://www.cdc.gov/diabetes/prevention/find-a-program.html** and additional resuorces at: **https://www.cdc.gov/diabetes/prevention/info-hcp.html** or call the **Nevada Quality Technical Assistance Center**: **702-616-4914.**
- The **Southern Nevada Health District** offers a free online diabetes education program in English: **https://app.gethealthyclarkcounty.org/training/diabetes/** and Spanish: **https://www.vivasaludable.org/training/diabetes/**

Eligibility for the diabetes prevention program

A. Inclusion criteria:

- Current age ≥18 years **and**
- Most recent BMI ≥24 (≥22 if Asian)* **and**
- A positive lab test result within previous 12 months:
  - HbA1C 5.7–6.4% (LOINC code 4548-4) **or**
  - FPG 100–125 mg/dL (LOINC code 1558-6) **or**
  - OGTT 140–199 mg/dL (LOINC code 62856-0) **or**
- History of gestational diabetes (ICD-9: V12.21; ICD-10: Z86.32)

B. Exclusion criteria:

- Current diagnosis of diabetes (ICD-9: 250.xx; ICD-10: E10.x, E11.x, E13.x and O24.x) **or**
- Current Insulin use

Consider referring eligible patients:

- At the time of an office visit, and/or
- By generating a list of eligible patients from your electronic health record using a structured query

Physicians and other health care providers should also use their independent judgment when referring to a diabetes prevention program.

* These BMI levels reflect eligibility for the National DPP as noted in the CDC Diabetes Prevention Recognition Program Standards and Operating Procedures. The American Diabetes Association (ADA) encourages screening for diabetes at a BMI of ≥23 for Asian Americans and ≥25 for non-Asian Americans, and some programs may use the ADA screening criteria for program eligibility. Please check with your diabetes prevention program provider for their specific BMI eligibility requirements.

Engaging patients

Patient risk assessment

DO YOU HAVE PREDIABETES?

Prediabetes 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)		

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.

If you scored 5 or higher:

You're likely to have prediabetes and are at high risk for 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, Hispanic/Latinos, American Indians, Asian Americans and Pacifi Islanders.

Higher body weights increase diabetes risk for everyone. Asian Americans are at increased diabetes risk at lower body weights than the rest of the general public (about 15 pounds lower).

Lower Your Risk

Here's the good news: it is possible with small steps to reverse prediabetes - and these measures can help you live a longer and healthier life.

If you are at high risk, the best thing to do is contact your doctor to see if additional testing is needed.

Visit **DoIHavePrediabetes.org** for more information on how to make small lifestyle changes to help lower your risk.

For more information, visit us at

DoIHavePrediabetes.org

Ad Council · American Diabetes Association. · AMA · CDC

96 MILLION AMERICANS ADULTS have prediabetes

You could be one of them.

Having prediabetes means you are at increased risk for developing serious health problems such as type 2 diabetes, stroke and heart disease.

You could have prediabetes if you have:

- High cholesterol **or**
- High blood pressure **or**
- A parent, brother or sister with diabetes

Your risk goes up if you are also overweight, and/or over age 45.

If you have prediabetes, we can help!

Ask your doctor how you can stop diabetes before it starts.

Are you at risk for prediabetes?

1 in 3 U.S. adults has prediabetes. Most don't know it. Are you at risk?

You may have prediabetes and be at risk for type 2 diabetes if you:

- Are 45 years of age or older
- Are overweight
- Have a family history of type 2 diabetes
- Have high blood pressure
- Are physically active fewer than three times per week
- Ever had diabetes while pregnant (gestational diabetes) or gave birth to a baby that weighed more than 9 pounds

Prediabetes can lead to serious health problems

Having prediabetes means your blood glucose (sugar) level is higher than normal, but not high enough to be diagnosed as diabetes. But, nearly 90 percent of adults who have prediabetes don't know they have it.

If you have prediabetes and don't lose weight or increase your physical activity, you could develop type 2 diabetes within five years. Type 2 diabetes is a serious condition that can lead to health issues such as heart attack, stroke, blindness, kidney failure, or loss of toes, feet or legs.

What can you do?

- Talk to your doctor about your risk of having prediabetes.

Here's the good news

If you have prediabetes, your doctor may refer you to a proven lifestyle change program that can help you prevent or delay getting type 2 diabetes.

The National Diabetes Prevention Program can help!

The National Diabetes Prevention Program (National DPP) uses a program that is proven to prevent or delay type 2 diabetes, and will help you lower your risk by improving your food choices and increasing physical activity.

How does it work? As part of a group in your community or online, you will work with a trained lifestyle coach to learn the skills you need to make lasting lifestyle changes. You will learn to eat healthy, add physical activity to your life, manage stress, stay motivated and solve problems that can get in the way of healthy changes.

Features

- Trained coach to guide and encourage you
- In-person or online
- CDC-approved program
- Support from others working on the same goals as you
- Skills to help you lose weight, be more physically active and manage stress
- Some insurance companies will cover

What participants are saying …

"I love having a lifestyle coach. She has given us great information, helped me stay on track and stay positive!"

—Bruce

"I'm so excited because I went to the doctor last week and all of my numbers were down and I officially no longer have prediabetes."

—Vivien

Now is the time to take charge of your health and make a change! Ask your doctor or nurse.

So you have prediabetes … now what?

Prediabetes means your blood glucose (sugar) level is higher than normal, but not high enough to be diagnosed as diabetes. This condition raises your risk of type 2 diabetes, stroke and heart disease.

What can you do about it?

The good news is that there's a program that can help you.

The National Diabetes Prevention Program, led by the Centers for Disease Control and Prevention (CDC), uses a method proven to prevent or delay type 2 diabetes.

By improving food choices and increasing physical activity, your goal will be to lose a minimum 5 percent weight loss—that is 10 pounds for a person weighing 200 pounds.

These lifestyle changes can cut your risk of developing type 2 diabetes by more than half.

How does the program work?

As part of a group, you will work with a trained diabetes prevention coach and other participants to learn the skills you need to make lasting lifestyle changes. You will learn to eat healthy, add physical activity to your life, manage stress, stay motivated and solve problems that can get in the way of healthy changes.

The program lasts one year, with 16 sessions taking place about once a week and six to eight more sessions meeting once a month. By going through the program with others who have prediabetes you can celebrate each other's successes and work together to overcome challenges.

Some insurance plans will cover the cost of the program. Check with your insurance provider to see if it is covered. Also, some places that provide the program will adjust the fee you pay based on your income.

Why should you act now?

Without weight loss and moderate physical activity, many people with prediabetes will develop type 2 diabetes within five years. Type 2 diabetes is a serious condition that can lead to health issues such as heart attack, stroke, blindness, kidney failure, or loss of toes, feet or legs. **NOW is the time to take charge of your health and make a change.**

Features of the program:

- A trained coach to guide and encourage you
- A CDC-approved program
- Group support
- Skills to help you lose weight, be more physically active and manage stress

What participants are saying …

"I love having a lifestyle coach. She has given us great information, helped me stay on track and stay positive!"

—Bruce

"I'm so excited because I went to the doctor last week and all of my numbers were down and I officially no longer have prediabetes."

—Vivien

Sign up today for a program near you!

To find a program in our area that is part of the National Diabetes Prevention Program, visit **cdc.gov/diabetes**

Incorporate screening, testing and referral into practice

In addition to the following resources, please view The Standards of Medical Care in Diabetes--2023, Abridged for Primary Care Providers:
https://diabetesjournals.org/care/issue/46/Supplement_1
(American Diabetes Association)
Diabetes Care 2023;46(Supplement_1):S5–S9
https://doi.org/10.2337/dc23-Srev
PubMed:
36507641

M.A.P. (Measure, Act, Partner)

THE M.A.P. (Measure, Act, Partner) to prevent type 2 diabetes—physicians and care teams can use this document to determine roles and responsibilities for identifying adult patients with prediabetes and referring to community-based diabetes prevention programs. "Point-of-Care" and "Retrospective" methods may be used together or alone.

Choose and check what works best for your practice

Step 1: Measure	When	Who	How (draw from AMA-CDC tools)
Point-of-care method • Assess risk for prediabetes during routine office visit • Test and evaluate blood glucose level based on risk status	• During vital signs	• Medical assistant • Nurse • Physician • Other_____	• Provide "Are you at risk for prediabetes?" patient education handout in waiting area • Use/adapt "Patient flow process" tool • Use CDC or ADA risk assessment questionnaire at check-in • Display 8 x 11" patient-facing poster promoting prediabetes awareness to your patients • Use/adapt "Point-of-care algorithm"
Retrospective method • Query EHR to identify patients with BMI ≥24; ≥22 if Asian* and blood glucose level in the prediabetes range	• Every 6–12 months	• Health IT staff • Other_____	• Use/adapt "Retrospective algorithm"
Step 2: Act			
Point-of-care method • Counsel patient re: prediabetes and treatment options during office visit • Refer patient to diabetes prevention program • Share patient contact info with program provider**	• During the visit	• Medical assistant • Nurse • Physician • Other_____	• Advise patient using "So you have prediabetes ... now what?" handout • Use/adapt "Health care practitioner referral form" • Refer to "Commonly used CPT and ICD codes"
Retrospective method • Inform patient of prediabetes status via mail, email or phone call • Make patient aware of referral and info sharing with program provider • Refer patient to diabetes prevention program • Share patient contact info with program provider**	• Contact patient soon after EHR query	• Health IT staff • Medical assistant (for phone calls) • Other_____	• Use/adapt "Patient letter/phone call" template • Use/adapt "Health care practitioner referral form" for making individual referrals • Use/adapt "Business Associate Agreement" template on AMA's website if needed
Step 3: Partner			
With diabetes prevention programs • Engage and communicate with your local diabetes prevention program • Establish process to receive feedback from program about your patients' participation	• Establish contact before making 1st referral	• Office manager • Other_____	Use/adapt "Business Associate Agreement" template on AMA's website if needed Refer to "Commonly used CPT and ICD codes"
With patients • Explore motivating factors important to the patient • At follow-up visit, order/review blood tests to determine impact of program and reinforce continued program participation • Discuss program feedback with patient and integrate into care plan	• During office visit • Other_____	• Medical assistant • Nurse • Physician • Other_____	• Advise patient using "So you have prediabetes ... now what?" handout and provide CDC physical activity fact sheet **www.cdc.gov/physicalactivity**

* These BMI levels reflect eligibility for the National DPP as noted in the CDC Diabetes Prevention Recognition Program Standards and Operating Procedures. The American Diabetes Association (ADA) encourages screening for diabetes at a BMI of ≥23 for Asian Americans and ≥25 for non-Asian Americans, and some programs may use the ADA screening criteria for program eligibility. Please check with your diabetes prevention program provider for their specific BMI eligibility requirements.

** To share patient contact information with a diabetes prevention program, you may need a Business Associate Agreement (BAA).

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Referring patients to a diabetes prevention program

Method 1:

Point-of-care identification and referral

Download and display patient materials

Download and print the practice and patient resources included in this guide in advance of patient visits, so your office can have them available in the waiting room or during consult.

Measure

Step 1 – During rooming/vitals:

A. If the patient is age 40 to 70 and is obese or overweight (USPSTF criteria), and does not have diabetes, proceed to the blood test.

B. If the patient is age ≥18 and does not have diabetes, nor meet the criteria in A, provide the self-screening risk test. If the self-screening test reveals high risk (score ≥ 5), proceed to calculating the patient's body mass index.

– The screening test can also be mailed to patient along with other pre-visit materials. If a patient completes the self-screening risk test, insert test results in the patient's paper chart or electronic medical record (EMR).

Step 2 – During exam/consult: Follow the "Point-of-care prediabetes identification algorithm" to determine if patient has prediabetes.

If the blood test results **do not** indicate prediabetes:

Encourage the patient to maintain healthy lifestyle choices. Continue with exam/consult.

Act

A. If the patient screens positive for prediabetes and has BMI <24 (<22 if Asian)*:

– Introduce the topic of prediabetes by briefly explaining what it is and its relation to diabetes (use the handout " So you have prediabetes ... now what?"). Review the patient's own risk factors.
– Emphasize the importance of prevention, including healthy eating, increased physical activity, and the elimination of risky drinking and tobacco use. (Visit the National Diabetes Education Program's GAME PLAN to Prevent Type 2 Diabetes for additional patient resources.)

B. If the patient screens positive for prediabetes and has BMI ≥24 (≥22 if Asian)*:

– Follow the steps in "A" above, discuss the value of participating in a diabetes prevention program, and determine the patient's willingness to let you refer him/her to a program.
– If the patient agrees, complete and send the referral form to a community-based or online diabetes prevention program, depending on patient preference.
– If patient declines, offer him/her a program handout and re-evaluate risk factors at next clinic visit.

Step 3 – Referral to diabetes prevention program: Most diabetes prevention programs are configured to receive referrals via conventional fax (over a phone line) or secure email. Complete the referral form and submit to a program as follows:

A. If using a paper referral form, send via fax (over a phone line) or scan and email

B. If the referral form is embedded in your EMR, either fax (over a phone line) or email using the EMR

– Some diabetes prevention programs can also receive an e-fax (over the Internet)

Physicians and other health care providers should also use their independent judgment when referring to a diabetes prevention program.

Partner

Step 4 – Follow-up with patient: Contact patient and troubleshoot issues with enrollment or participation. At the next visit, ask patient about progress and encourage continued participation in the program.

* These BMI levels reflect eligibility for the National DPP as noted in the CDC Diabetes Prevention Recognition Program Standards and Operating Procedures. The American Diabetes Association (ADA) encourages screening for diabetes at a BMI of ≥23 for Asian Americans and ≥25 for non-Asian Americans, and some programs may use the ADA screening criteria for program eligibility. Please check with your diabetes prevention program provider for their specific BMI eligibility requirements.

Point-of-care prediabetes identification

MEASURE

If the patient is age 40-70 (USPSTF criteria), is obese or overweight, and does not have diabetes, proceed to the blood test.

If the patient is age >18 and does not have diabetes, nor meet the criteria above, provide self-screening test, and if self-screening test reveals high risk, proceed to next step. Note : If a child is > age 10 and is obese, or if BMI ≥ 85% and they have risk factors, screen for prediabetes and diabetes http://clinical.diabetesjournals.org/content/37/1/11?.

Review medical record to determine if BMI ≥24* (≥22 if Asian) or history of GDM**

NO

If no: Patient does not currently meet program eligibility requirements

YES

Determine if a HbA1C, FPG or OGTT was performed in the past 12 months

NO

YES

Diagnostic test	Normal	Prediabetes	Diabetes
HbA1C(%)	< 5.7	5.7–6.4	≥ 6.5
Fasting plasma glucose (mg/dL)	< 100	100–125	≥ 126
Oral glucose tolerance test (mg/dL)	<140	140–199	≥ 200

ACT

Encourage patient to maintain a healthy lifestyle.

Continue with exam/ consult. Retest within three years of last negative test.

Refer to diabetes prevention program, provide brochure.

Consider retesting annually to check for diabetes onset.

Confirm diagnosis; retest if necessary.

Counsel patient re: diagnosis.

Initiate therapy.

PARTNER

Communicate with your local diabetes prevention program.

Contact patient and troubleshoot issues with enrollment or participation. At the next visit, ask patient about progress and encourage continued participation in the program.

Adapted from: New York State Department of Health. New York State Diabetes Prevention Program (NYS DDP) prediabetes identification and intervention algorithm. New York: NY Department of Health; 2012.

* These BMI levels reflect eligibility for the National DPP as noted

Prevention Recognition Program Standards and Operating Procedures. The American Diabetes Association (ADA) encourages screening for diabetes at a BMI of ≥23 for Asian Americans and ≥25 for non-Asian Americans, and some programs may use the ADA screening criteria for program eligibility. Please check with your diabetes prevention program provider for their specific BMI eligibility requirements.

** History of GDM = eligibility for diabetes prevention program.

Method 2:

Retrospective identification and referral

Step 1 – Query EMR or patient database

Measure

Query your EMR or patient database every 6–12 months using the following criteria:

A. Inclusion criteria:

- Age ≥18 years **and**
- BMI ≥24 (≥22 if Asian)* **and**
- A positive test result for prediabetes within the preceding 12 months:
  - HbA1C 5.7–6.4% **or**
  - Fasting plasma glucose 100–125 mg/dL **or**
  - Oral glucose tolerance test 140–199 mg/dL **or**
- Clinically diagnosed gestational diabetes during a previous pregnancy

B. Exclusion criteria:

- Current diagnosis of diabetes **or**
- Current Insulin use

Generate a list of patient names and other information required to make referrals:

- Gender and birth date
- Mailing address
- Email address
- Phone number

Act

Step 2 – Referral to diabetes prevention program

A. Contact patients via phone, email, letter or postcard to explain their prediabetes status and let them know about the diabetes prevention program.

B. Send relevant patient information to your local (or online) diabetes prevention program coordinator and have him/her contact the patient directly (may require Business Associate Agreement).

C. Flag patients' medical records for their next office visit.

Physicians and other health care providers should also use their independent judgment when referring to a diabetes prevention program.

Partner

During the next office visit, discuss diabetes prevention program participation:

- If the patient is participating, discuss program experience and encourage continued participation
- If the patient has declined to participate, stress the importance of lifestyle change and continue to encourage participation (use the handout "So you have prediabetes ... now what?")

* These BMI levels reflect eligibility for the National DPP as noted in the CDC Diabetes Prevention Recognition Program Standards and Operating Procedures. The American Diabetes Association (ADA) encourages screening for diabetes at a BMI of ≥23 for Asian Americans and ≥25 for non-Asian Americans, and some programs may use the ADA screening criteria for program eligibility. Please check with your diabetes prevention program provider for their specific BMI eligibility requirements.

Retrospective prediabetes identification

MEASURE

Query EMR or patient database every 6–12 months using the following criteria:

A. Inclusion criteria:
- Age ≥18 years **and**
- Most recent BMI ≥24 (≥22 if Asian)* **and**
- A positive lab test result within previous 12 months:
  - HbA1C 5.7–6.4% (LOINC code 4548-4) **or**
  - FPG 100–125 mg/dL (LOINC code 1558-6) **or**
  - OGTT 140–199 mg/dL (LOINC code 62856-0) **or**
- History of gestational diabetes (ICD-10: Z86.32)

B. Exclusion criteria:
- Current diagnosis of diabetes (ICD-10: E10.x, E11.x, E13.x and O24.x) **or**
- Current Insulin use

Generate a list of patient names with relevant information

ACT

Use the patient list to:

A. Contact patients to inform of risk status, explain prediabetes, and share info on diabetes prevention programs, **and/or**

B. Send patient info to diabetes prevention program provider
- Program coordinator will contact patient directly, **and**

C. Flag medical record for patient's next office visit

PARTNER

Discuss program participation at next visit

* These BMI levels reflect eligibility for the National DPP as noted in the CDC Diabetes Prevention Recognition Program Standards and Operating Procedures. The American Diabetes Association (ADA) encourages screening for diabetes at a BMI of ≥23 for Asian Americans and ≥25 for non-Asian Americans, and some programs may use the ADA screening criteria for program eligibility. Please check with your diabetes prevention program provider for their specific BMI eligibility requirements.





Letter template

Use/adapt these templates to conduct effi ient follow-up and referral with patients who have been identified as having prediabetes

<<YOUR LETTERHEAD>>
<<ADDRESS>>
<<PHONE NUMBER>>

<<DATE>>

<<PATIENT NAME>>
<<PATIENT ADDRESS>>

Dr. Mr./Mrs. <<PATIENT LAST NAME>>,

Thank you for being a patient of the <<PRACTICE NAME HERE>>. We are writing to tell you about a service to help make your health better.

Based on our review of your medical chart, you have a condition known as prediabetes. This means your blood sugar is higher than normal, which increases your risk of developing serious health problems including type 2 diabetes, as well as heart disease and stroke.

We have some good news. Our office wants you to know that you may be eligible for a diabetes prevention program run by our partners, <<NAME OF PROGRAM PROVIDER>>. This program is proven to reduce your risk of developing diabetes and other health problems.

We have sent a referral to <<NAME OF PROGRAM PROVIDER>> and someone will call you to discuss the program, answer any questions you may have and, if you are interested, enroll you in the program.

Please feel free to give <<NAME OF PROGRAM PROVIDER>> a call at <<PHONE NUMBER>>.

–OR–

We have sent a referral to <<NAME OF PROGRAM PROVIDER>> and we urge you to call <<PHONE NUMBER>> to learn more about the program and enroll.

We hope you will take advantage of this program, which can help prevent you from developing serious health problems.

Sincerely,

Dr. <<PHYSICIAN LAST NAME>>





Sample "Talking points" for phone outreach

- Hello <<PATIENT NAME>>.
- I am calling from <<PRACTICE NAME HERE>>.
- I'm calling to tell you about a program we'd like you to consider, to help you prevent some serious health problems.
- Based on our review of your medical chart, you have a condition known as prediabetes. This means your blood sugar is higher than normal, which makes you more likely to develop serious health problems including type 2 diabetes, stroke and heart disease.
- We have some good news, too.
- You may be eligible for a diabetes prevention program run by our partners, <<NAME OF PROGRAM PROVIDER>>.
  - Their program is based on research proven to reduce your risk of developing diabetes and other health problems.

Option A

- We have sent a referral to <<NAME OF PROGRAM PROVIDER >> and someone will call you to discuss the program, answer any questions you may have and, if you are interested, enroll you in the program.
- Please feel free to give <<NAME OF PROGRAM PROVIDER>> a call at <<PHONE NUMBER>>.
- Do you have any questions for me?
- Thank you for your time and be well.

Option B

- We have sent a referral to <<NAME OF PROGRAM PROVIDER>> and we urge you to call <<PHONE NUMBER>> to learn more about the program and enroll.
- We hope you will take advantage of this program, which can help prevent you from developing serious health problems.
- Do you have any questions for me?
- Thank you for your time and be well.

Referral form to a diabetes prevention program

Send to: Fax: **Email:**

PATIENT INFORMATION	
First name	Address
Last name	
Health insurance	City
Gender ☐Male ☐Female	State
Birth date (mm/dd/yy)	ZIP code
Email	Phone
By providing your information above, you authorize your health care practitioner to provide this information to a diabetes prevention program provider, who may in turn use this information to communicate with you regarding its diabetes prevention program.	

PRACTITIONER INFORMATION (COMPLETED BY HEALTH CARE PRACTITIONER)	
Physician/NP/PA	Address
Practice contact	City
Phone	State
Fax	ZIP code

SCREENING INFORMATION		
Body Mass Index (BMI)	Eligibility = ≥24 (≥22 if Asian)*	
Blood test (check one)	Eligible range	Test result (one only)
☐ Hemoglobin A1C	5.7–6.4%	_____
☐ Fasting Plasma Glucose	100–125 mg/dL	_____
☐ 2-hour plasma glucose (75 gm OGTT)	140–199 mg/dL	_____
Date of blood test (mm/dd/yy):		
For Medicare requirements, I will maintain this signed original document in the patient's medical record.		
Date	**Practitioner signature**	

OPTIONAL

By signing this form, I authorize my physician to disclose my diabetes screening results to the (insert program/organization name here) for the purpose of determining my eligibility for the diabetes prevention program and conducting other activities as permitted by law.

I understand that I am not obligated to participate in this diabetes screening program and that this authorization is voluntary.

I understand that I may revoke this authorization at any time by notifying my physician in writing. Any revocation will not have an effect on actions taken before my physician received my written revocation.

Date **Patient signature**

IMPORTANT WARNING: The documents accompanying this transmission contain confidential health information protected from unauthorized use or disclosure except as permitted by law. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted to do so by law or regulation. If you are not the intended recipient and have received this information in error, please notify the sender immediately for the return or destruction of these documents. Rev. 05/30/14

* These BMI levels reflect eligibility for the National DPP as noted in the CDC Diabetes Prevention Recognition Program Standards and Operating Procedures. The American Diabetes Association (ADA) encourages screening for diabetes at a BMI of ≥23 for Asian Americans and ≥25 for non-Asian Americans, and some programs may use the ADA screening criteria for program eligibility. Please check with your diabetes prevention program provider for their specific BMI eligibility requirements.

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: ☐ Male ☐ Female ☐ _____

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
- ☐ Hearing
- ☐ Language
- ☐ Cognitive
- ☐ Physical
- ☐ Social distancing during pandemic
- ☐ 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

☐ Annual follow-up MNT 2 hours

☐ Additional MNT hours for change in:

☐ medical condition ☐ treatment ☐ diagnosis.

Signature and NPI # _____ Date _____/_____/_____

Group/practice name, address and phone:_____

BMI calculation chart

WEIGHT / HEIGHT	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	53	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	35	36	37	39	40	41	42	44	45	46	48	49	50	51
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	43	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	36	37	38	39	40	42	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

International Classification of Diseases ICD-9 and ICD-10 prediabetes and diabetes screening			
ICD-10 code (effective 10-01-2015)	**ICD-10 code description**	**ICD-9 code (effective through 9-30-2015)**	**ICD-9 code description**
Z13.1	Encounter for screening for diabetes mellitus	**V77.1**	Diabetes screening
R73.09	Other abnormal glucose	**790.29**	Abnormal glucose
R73.01	Impaired fasting glucose	**790.21**	Impaired fasting glucose
R73.02	Impaired glucose tolerance (oral)	**790.22**	Impaired glucose tolerance (oral)
R73.9	Hyperglycemia, unspecified	**790.29**	Other abnormal glucose NOS
E66.01	Morbid obesity due to excess calories	**278.01**	Morbid Obesity
E66.09	Other obesity due to excess calories	**278.00**	Obesity (NOS)
E66.8	Other obesity	**278.00**	Obesity (NOS)
E66.9	Obesity, unspecified	**278.00**	Obesity (NOS)
E66.3	Overweight	**278.02**	Overweight
Z68.3x	Body mass indexes 30.0-39.9 (adult)	**V85.30-V85.39**	Body mass indexes 30.0-39.9 (adult)
Z68.4x	Body mass indexes ≥40.0 (adult)	**V85.41-V85.45**	Body mass indexes 30.0-39.9 (adult)

Current Procedural Terminology (CPT®) for diabetes screening tests			
CPT E/M codes for prevention-related office visits		**CPT codes for office-based laboratory testing**	
Preventive Visit New Patient Commercial/Medicaid	99381-99387	83036QW	Office-based Hemoglobin A1C testing
Preventive Visit Established Patient Commercial/Medicaid	99391-99397	82962	Office-based finger stick glucose testing
Annual Wellness Visit Initial Medicare	G0438		
Annual Wellness Visit Subsequent Medicare	G0439		

(Continued on next page)

Current Procedural Terminology (CPT®) for diabetes screening tests			
CPT E/M codes for prevention-related office visits		**CPT codes for office-based laboratory testing**	
Individual Preventive Counseling* Commercial/Medicaid	99401 – Approx 15min 99402 – Approx 30min 99403 – Approx 45min 99404 – Approx 60min		
Face-to-Face Obesity	G0447 – 15 minutes		
Counseling for Obesity† Medicare			

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

* Preventive codes 99381-99397 include counseling and cannot be combined with additional counseling codes. If significant risk factor reduction and/or behavior change counseling is provided during a problem-oriented encounter, additional preventive counseling may be billed. In this case, modifier 25 code may allow for payment for both services, although this may vary by payer. Reimbursement for this code is not guaranteed.

†Must be billed with an ICD code indicating a BMI of 30 or greater. Medicare does not allow billing for another service provided on the same day.

Nevada Resources:

The **National Diabetes Prevention Program** is available in Nevada. Call the Nevada QTAC **702-616-4914** for info or visit: **https://dprp.cdc.gov/Registry** or **https://nvqtac.org**

The **Nevada Tobacco Quitline**: Refer eligible patients to receive free counseling: 1-800-QUITNOW (1-800-784-8669) or in Spanish: 1-855-DÉJELO-YA (1-855-335-3569).

National Diabetes Prevention Coverage Toolkit: coveragetoolkit.org

Diabetes Prevention Impact Toolkit: Use the toolkit to project the health and economic effects of the National DPP lifestyle change program for your population: **https://nccd.cdc.gov/toolkit/diabetesimpact**

The Nevada Diabetes Association developed the **Nevada Diabetes Resource Directory** that includes statewide diabetes resources: **https://diabetesnv.org/resources-information/resource-directory/**

Diabetes 2021 Report Card CDC: includes Nevada data: **https://www.cdc.gov/diabetes/resources-publications/index.html**

The **Southern Nevada Health District** offers free online diabetes prevention programs and healthy lifestyle apps to prescribe your patients: **https://gethealthyclarkcounty.org/community-tools/healthcare/**

- For programs and resources in SP, visit: **www.vivasaludable.org**
- Find diabetes data at: **www.healthysouthernnevada.org**

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Chronic Disease Resources

The Southern Nevada Health District's Office of Chronic Disease Prevention and Health Promotion offers free online programs and mobile apps to help you reduce your risk of chronic disease. You can also find information to help you better self-manage chronic conditions as well as other community resources on our website: GetHealthyClarkCounty.org.

Diabetes

ONLINE PROGRAM / DIABETES CLASSES

The **Road to Diabetes Prevention** is a free online program that 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: **https://app.gethealthyclarkcounty.org/training/diabetes**. Find free diabetes self-management classes and additional programs and resources to prevent or manage diabetes on our website: **www.gethealthyclarkcounty.org/manage-your-risk/diabetes**.

Heart and Stroke

OUTREACH AND EDUCATION

Do you know your numbers? Our online resources and education tools can help you learn how to manage your blood pressure and cholesterol 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 get your blood pressure checked regularly. Find where to get your blood pressure checked for free at **www.gethealthyclarkcounty.org/community-calendar**. For more information on how to manage your risk and learn tips on how to achieve a healthy lifestyle visit **www.gethealthyclarkcounty.org/manage-your-risk**.

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

Nutrition

ONLINE PROGRAMS AND MOBILE APPS

The **Nutrition Challenge** is an eight-week online program that helps you increase your fruit and vegetable intake. **Half My Plate** is a tracker/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. Visit **www.gethealthyclarkcounty.org/eat-better** to learn more.

Physical Activity

ONLINE PROGRAMS AND MOBILE APPS

Walk Around Nevada and **Neon to Nature** are online programs/apps you can join with family and friends to find and visit beautiful trails or virtually walk around Nevada. Adults need at least 150 minutes of activity each week. Find additional tips at **www.gethealthyclarkcounty.org/get-moving**.

Tobacco Use

PHONE-BASED SUPPORT

The **Nevada Tobacco Quitline** is a FREE phone-based service available to Nevada residents 13 years of age or older. 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. Call **1-800-QUIT-NOW (1-800-784-8669)** from a Nevada area code phone. Services are offered in many languages, and the Quitline is open seven days a week from 4 a.m. to 10 p.m.

Rev. 4-1-21

Recursos para Enfermedades Crónicas

La oficina de Prevención de Enfermedades Crónicas y Promoción de Salud del Distrito de Salud del Sur de Nevada, ofrece programas en línea gratuitos y aplicaciones móviles para ayudarle a reducir los factores de riesgo de enfermedades crónicas. También puede encontrar información para ayudarle a gestionar mejor las condiciones crónicas, así como otros recursos comunitarios en nuestro sitio web: vivasaludable.org

Diabetes

PROGRAMA EN LÍNEA / CLASES DE DIABETES

El **Camino a la Prevención de la Diabetes*** es un programa en línea gratuito, que puede ayudarle 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: **www.vivasaludable.org/training/diabetes**. Encuentre clases gratuitas para el autocontrol de la diabetes y recursos adicionales para prevenir o controlar la diabetes en nuestro sitio web: **www.vivasaludable.org/manage-your-risk/diabetes**.

Enfermedades cardiovasculares

ALCANCE COMUNITARIO Y EDUCACIÓN

¿Conoce sus números?* Nuestros recursos en línea y herramientas educativas pueden ayudarle a aprender cómo controlar su presión arterial y colesterol, para reducir su riesgo de desarrollar enfermedades cardiacas y accidente cerebrovascular. Tome medidas para estar más activo físicamente, comer más sano, deje de usar productos de tabaco y revise su presión arterial regularmente. Encuentre donde medir su presión arterial gratuitamente en **www.gethealthyclarkcounty.org/community-calendar**. Para obtener más información sobre cómo gestionar el riesgo y aprender consejos sobre cómo lograr un estilo de vida saludable, visite **www.vivasaludable.org/manage-your-risk/heart-disease**.

Nutrición

PROGRAMAS EN LÍNEA Y APLICACIONES MÓVILES

El **Reto de Nutrición*** es un programa en línea de ocho semanas que le ayuda a aumentar su consumo de frutas y verduras. **La mitad de mi plato** es un rastreador/aplicación que le ayuda a alcanzar sus metas para una dieta saludable inspirando a hacer la mitad del plato con frutas y verduras **www.vivasaludable.org/eat-better/nutrition-challenge**. La aplicación **SNAP Cooking*** cuenta con cientos de recetas fáciles y de bajo costo justo al alcance de su mano. Para obtener más información visite **www.vivasaludable.org**.

Actividad física

PROGRAMAS EN LÍNEA Y APLICACIONES MÓVILES

Caminando Alrededor de Nevada* y **Neón a la Naturaleza** son programas en línea/aplicaciones que puede unirse con su familia y amigos para encontrar y visitar hermosos senderos o virtualmente caminar alrededor de Nevada. Los adultos necesitan al menos 150 minutos de actividad cada semana. Encuentra consejos adicionales en **www.vivasaludable.org/get-moving/community-activities/walk-around-nevada** y **www.vivasaludable.org/get-moving/community-activities/neon-to-nature**.

Uso del tabaco

APOYO BASADO EN EL TELÉFONO

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. 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. Llame ahora a la línea de ayuda desde un teléfono con código de área de Nevada al **1-855-DÉJELO-YA (1-855-335-3569)**. Los servicios se ofrecen en muchos idiomas siete días a la semana 4 a.m.–10 p.m.

VIVA Saludable

www.vivasaludable.org

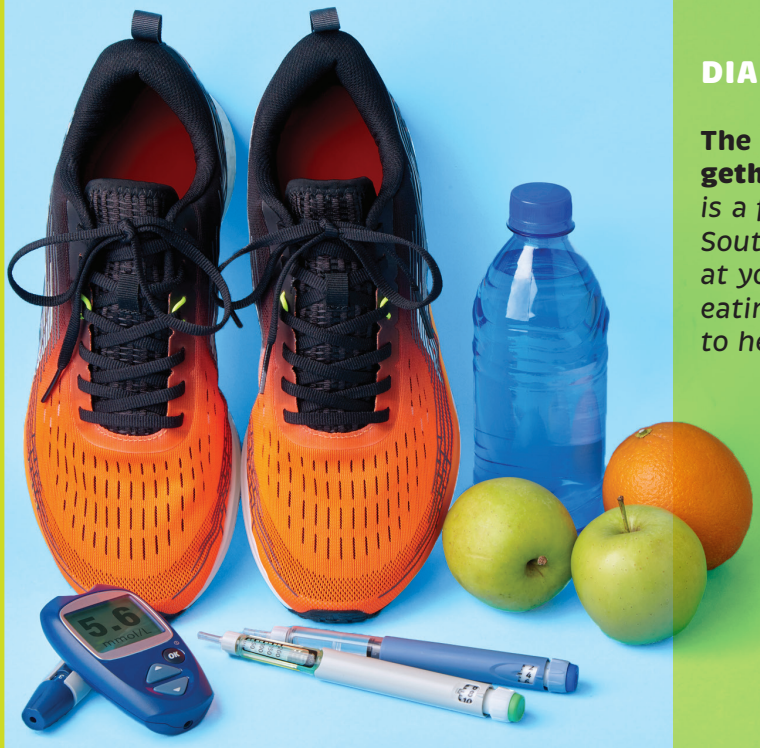
Distrito de Salud del Sur de Nevada
Southern Nevada Health District
280 S. Decatur Blvd. • Las Vegas, NV 89107

Póngase en contacto con nosotros en vivasaludable@snhd.org o 702-759-1270

*** Algunos de los programas en línea y aplicaciones están disponible en español.**

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/training/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**

www.get**healthy**clarkcounty.org
GET MOVING. EAT BETTER. LIVE TOBACCO-FREE.

SNHD Southern Nevada Health District

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.

Alliance Against Diabetes Clinic
(702) 207-0400 | allianceagainstdiabetes.org

Las Vegas: 3530 E Flamingo Rd #105

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 110

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 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

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

Cambridge
3900 Cambridge St., Ste. 102

Eastern Dental and Medicine
2212 S. Eastern Ave.
Dental appointments call (702) 597-3898

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

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

CP Squires School Based Health Center
1312 E Tonopah Ave.

Las Vegas Outreach Clinic (Homeless)
47 W Owens Ave.

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

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: 2215 Renaissance Dr., Ste. C

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.get**healthy**clarkcounty.org
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