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

DIABETES SELF-MANAGEMENT EDUCATION

This publication was supported by the Nevada State Division of Public and Behavioral Health through Grant Number 1 NU58DP006538-05-00 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Division nor Centers for Disease Control and Prevention.

Revised March 2023

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

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

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

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

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

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

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

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

1 Funnell MM, Anderson RM: Empowerment and self-management of diabetes. Clinical Diabetes 2004; 22(3): 123-127.
2 Heinrich E, Schaper NC, de Vries NK. Self-management interventions for type 2 diabetes: a systematic review. Eur Diabetes Nurs. 2010;7:71–6.
3 American Diabetes Association/American Association of Diabetes Educators National Standards
4 Standards of Practice and Standards of Professional Performance for Registered Dietitians (Generalist, Specialty, and Advanced) in Diabetes Care
5 Cochran J, Conn VS. Meta-analysis of quality of life outcomes following diabetes self-management training. Diabetes Educ. 2008;34:815–23.

Overview of guide tools

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

Engage clinicians

Team Care Approach for Diabetes Management[6]

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

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

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

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

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

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

Patients who receive Diabetes Self-Management Education:

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

ADCES7™ Self-Care Behaviors:

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

Working with Certified Diabetes Educator and Diabetes Education Team

DSME is a team-based approach where educators work with clinicians to promote the best possible health outcomes for patients. Diabetes educators are licensed health care professionals, including registered nurses, registered dieticians, and pharmacists. Many of the health care professionals who provide DSME services through accredited programs also carry the designation Certified Diabetes Care & Education Specialist (CDCES). In addition to certified DSME providers, professional health education specialists and community health workers (CHWs) also play a role in meeting unmet needs for diabetes education in underserved communities. CHWs can bridge language, cultural and traditional barriers to achieve positive health outcomes for patients with diabetes. This team approach specializes in helping people with diabetes to learn the skills that best self-manage their diabetes. While the clinician focuses on 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[7]).

Benefits of Partnering Within a DSME Team Model

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

How Do Diabetes Educators Help?

Learn Basic Information	**Understand** How to Use Devices	**Adopt** Healthy Eating and Physical Activity Habits
• Seven tenets of self-care behavior (ADCES7) • Incorporating diabetes management into life	• Blood glucose meters • Insulin pens • Insulin pumps • Continuous glucose monitors	• Nutrition education • Meal planning • Weight loss strategies

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





Eligibility and Insurance Coverage for DSME

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

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

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

Medicare[9]

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

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

8 https://chronicdisease.org/tag/diabetes
9 https://www.cdc.gov/diabetes/dsmes-toolkit/reimbursement/medicare.html

https://www.cdc.gov/diabetes/dsmes-toolkit/index.html

Nevada Medicaid

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

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

How to Code for DSME

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

Importance of follow-up after a referral to DSME

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

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

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

Engage patients

Patient risk assessment

ARE YOU AT RISK FOR

TYPE 2 DIABETES?

American Diabetes Association®

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.

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)

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 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.

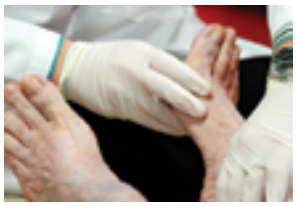
Visit diabetes.org or call 1-800-DIABETES for information, tips on getting started, and ideas for simple, small steps you can take to help lower your risk.

STOP DIABETES®

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

To team up with my pharmacist, I will—

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



To team up with my podiatrist, I will—

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

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

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

To team up with my dental provider, I will—

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

To control my diabetes every day, I will—

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

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

National Institutes of Health

National Diabetes Education Program NDEP
A program of the National Institutes of Health and the Centers for Disease Control and Prevention
CS241400-B NDEP-128

Managing Diabetes

Diabetes Self-Management Education
Ask Your Doctor

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

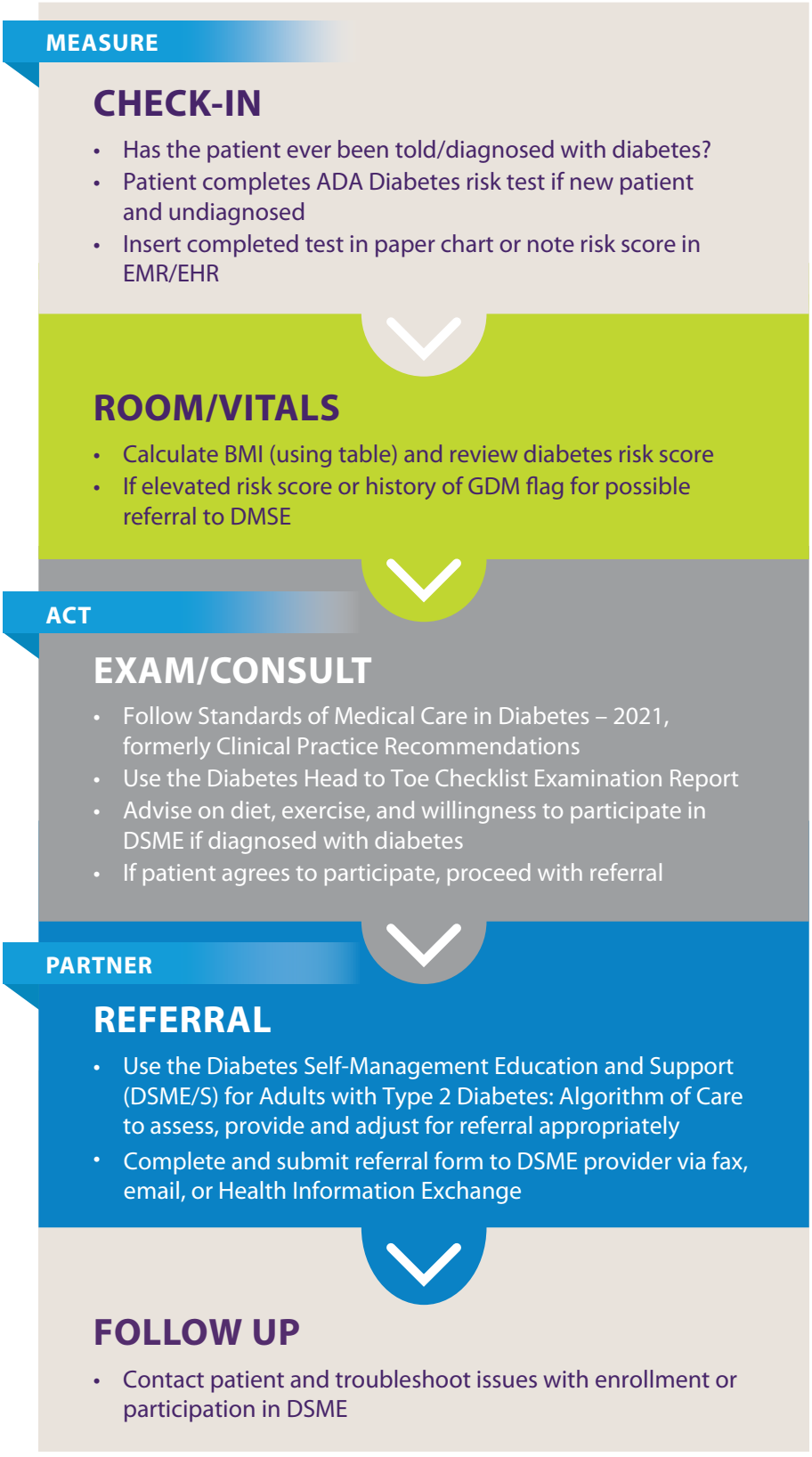
People who learn to manage their diabetes have fewer health problems from diabetes even years later. You can too. Learn how to better manage your diabetes by attending a Diabetes Self-Management Education Program.

Ask your doctor about referring you to a program.

This publication was supported by the Nevada State Division of Public and Behavioral Health through Grant Number 1 NU58DP006538-05-00 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Division nor Centers for Disease Control and Prevention.

Incorporate screening, testing and referral into practice

Sample patient flow process







Point-of-Care: Diabetes Identification

(Excerpts from the abridged version of the American Diabetes Association Position Statement: The Standards of Medical Care in Diabetes--2023

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

Criteria for the Diagnosis of Prediabetes and Diabetes

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

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

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

Criteria for Testing for Diabetes or Prediabetes in Asymptomatic Adults[11]

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

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

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

There are 4 critical times to assess, provide, and adjust DSME/S: (1) with a new diagnosis of type 2 diabetes, (2) Annually for health maintenance and prevention of complications, (3) when new complicating factors influence self-management, and (4) when transitions in care occur. Included below are the DSME/S Algorithm of Care and Algorithm: Action Steps. See, Powers et al, (2017, Jan 24). Diabetes Self-management Education and Support in Type 2 Diabetes: A Joint Position Statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics: *The Diabetes Educator OnlineFirst,* Volume 43, 1; for the complete guidance.
https://journals.sagepub.com/toc/tdeb/current

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

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

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

1	2	3	4
At diagnosis	**Annual** assessment of education, nutrition, and emotional needs	When new **complicating factors** influence self-management	When **transitions** in care occur
When primary care provider or specialist should consider referral:			
• 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	• Needs review of knowledge, skills, and behaviors • Long-standing diabetes with limited prior education • Change in medication, activity, or nutritional intake • HbA1c out of target • Maintain positive health outcomes • Unexplained hypoglycemia or hyperglycemia • Planning pregnancy or pregnant • For support to attain and sustain behavior change(s) • Weight or other nutrition concerns • New life situations and competing demands	Change in: • 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

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

At diagnosis	**Annual** assessment of education, nutrition, and emotional needs	When new **complicating factors** influence	When **transitions** in care occur
Primary care provider/endocrinologist/clinical care areas of focus and action steps			
• Answer questions and provide emotional support regarding diagnosis • Provide overview of treatment and treatment goals • Teach survival skills to address immediate requirements (safe use of medication, hypoglycemia treatment if needed, introduction of eating guidelines) • Identify and discuss resources for education and ongoing • Make a referral for DSME/S and MNT	• Assess all areas of self-management • Review problem-solving skills • Identify strengths and challenges of living with diabetes	• Identify presence of factors that affect diabetes self-management and attain treatment and behavioral goals • Discuss effect of complications and successes with treatment and self-management	• Develop diabetes transition plan • Communicate transition plan to new health care team members • Establish DSME/S regular follow-up care
Diabetes education: areas of focus and action steps *			
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 adaptions in diabetes self-management • Provide support for independent self-management skills and self-efficacy • Identify level of significant other involvement and facilitate education and support • Assist with facing challenges affecting usual level of activity, ability to function, health beliefs, and feeling of well-being • Maximize quality of life and emotional support for the patient (and family members) • Provide education for others now involved in care • Establish communication and follow-up plans with the provider, family and others

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

Diabetes Self-Management in Nevada

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

Diabetes Education Providers/Programs

The Association of Diabetes Care & Education Specialists list accredited diabetes education programs in Nevada: Find diabetes programs: **https://nf01.diabeteseducator.org/eweb/DynamicPage.aspx?Site=aade&WebCode=DEAPFindApprovedProgram**

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

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

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

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

Additional Diabetes Resources

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

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

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

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

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

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

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

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

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

ORDER FORM

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

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

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

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

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

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

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

PATIENT INFORMATION

Last Name _____ First Name _____ Middle _____

Date of Birth _____/_____/_____ Gender: ☐ 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:_____

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.**

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

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

These codes may be useful to report services/tests performed to screen for prediabetes and diabetes.
Find updated codes and resources (AMA): https://amapreventdiabetes.org/ and:
https://amapreventdiabetes.org/tools-resources

References
American Medical Association 2023, **https://amapreventdiabetes.org/**

The American Medical Association and the Centers for Disease Control are supporting physicians, care teams and patients to prevent diabetes.

This publication was supported by the Nevada State Division of Public and Behavioral Health through Grant Number 1 NU58DP006538-05-00 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Division nor Centers for Disease Control and Prevention.