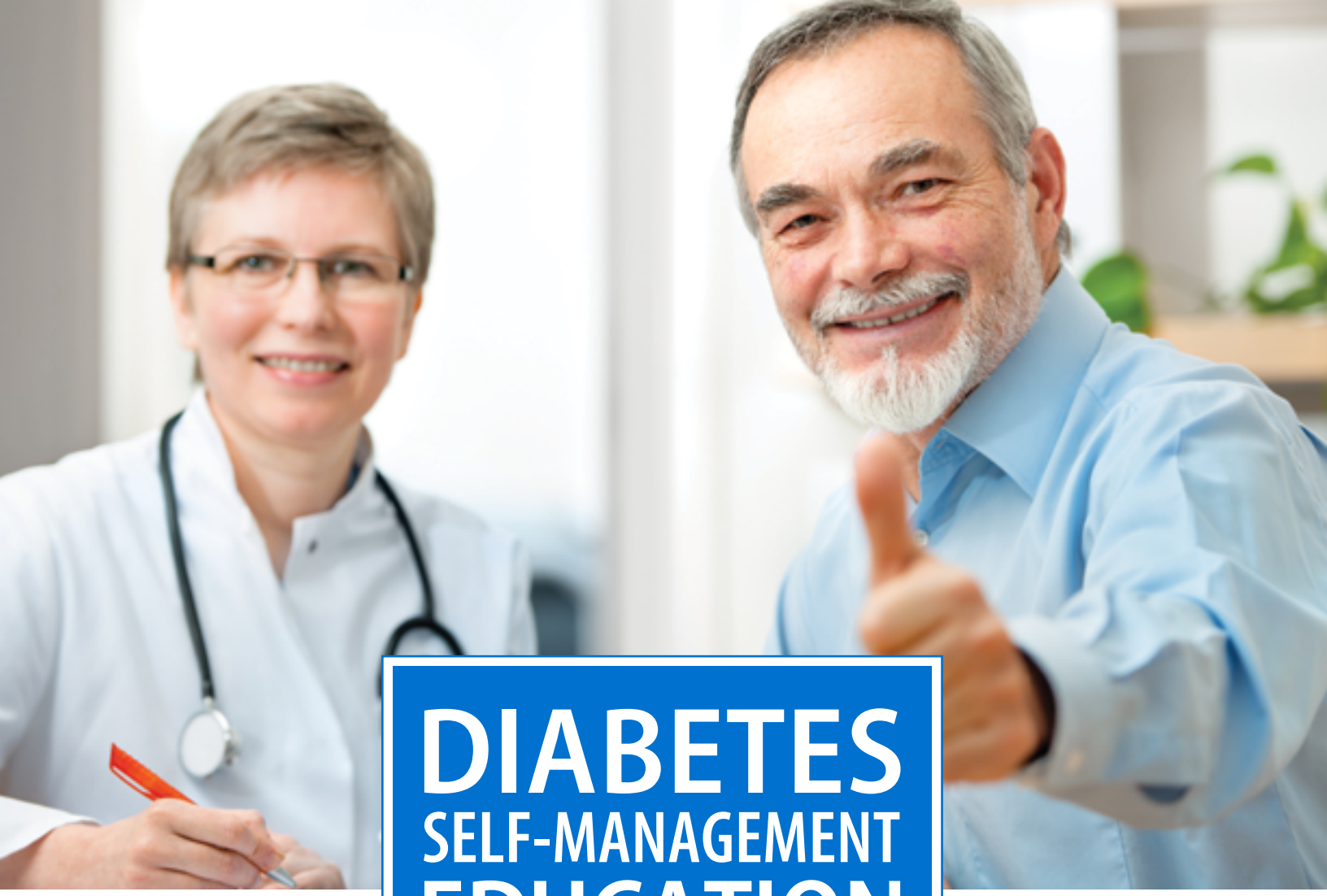


DIABETES SELF-MANAGEMENT EDUCATION

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

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

NEVADA Wellness

NVDiabetesEd.org

Supported by the Nevada State Division of Public and Behavioral Health through grant number 3U58DP004820-02W1 from the Centers for Disease Control and Prevention.

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 Diebetes 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 http://www.cdc.gov/diabetes/ndep/pdfs/ppod-guide-team-care-approach.pdf

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

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

Patients who receive Diabetes Self-Management Education:

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

AADE7™ Self-Care Behaviors:

The AADE developed seven self-care behaviors (the AADE7) that make up the core of DSME programs:

NevadaWellness.org NEVADA Wellness NVDiabetesEd.org

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

Working with Certified Diabetes Educator and Diabetes Education Team

DSME is a team-based approach where educators work with clinicians to promote the best possible health outcomes for patients. Diabetes educators are licensed health care professionals, including registered nurses, registered dieticians, and pharmacists. Many of the health care professionals who provide DSME services through accredited programs also carry the designation Certified Diabetes Educator (CDE). In addition to certified DSME providers, community health workers (CHWs) also play a role in meeting unmet needs for diabetes education in underserved communities. CHWs can bridge language, cultural and traditional barriers to achieve positive health outcomes for patients with diabetes. This team approach specializes in helping people with diabetes learn the skills to best self-manage their diabetes. While the clinician focuses on proving the highest clinical care to the patient, the DSME provider focuses on providing the counseling, education, training and support known as Diabetes Self-Management Education (DSME) or Diabetes Self-Management Training (DSMT[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 (AADE7) • Incorporating diabetes management into life	• Blood glucose meters • Insulin pens • Insulin pumps • Continuous glucose monitors	• Nutrition education • Meal planning • Weight loss strategies

7 http://www.chronicdisease.org/?page=DiabetesDSMEresource





Eligibility and Insurance Coverage for DSME

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

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

- The training and education provided to the insured after he is initially diagnosed with diabetes which is medically necessary for the care and management of diabetes, including, without limitation, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes;
- Training and education which is medically necessary as a result of a subsequent diagnosis that indicates a significant change in the symptoms or condition of the employee or member of the insured group and which requires modification of his program of self-management of diabetes; and
- Training and education which is medically necessary because of the development of new techniques and treatment for diabetes.
- Check with the insureds 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 http://www.chronicdisease.org/?page=DiabetesDSMEresource#Desired%20outcomes
9 http://www.chronicdisease.org/default.asp?page=DiabetesDSMEresource#National%20Standards%20for%20DSME/T

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. (AADE-accredited program inclusion in Nevada Medicaid's DSME policy is currently under review).
- Certification as a diabetes educator by the National Board of Diabetes Educators is required.
- **PRIOR AUTHORIZATION IS REQUIRED** when recipients require additional or repeat training sessions that exceed ten hours of training. Indications for repeat training Prior Authorization (PA) is required for recipients whose diabetes is poorly controlled include:
  a. Hemoglobin A1c blood levels of 8.5 or greater.
  b. Four or more serious symptomatic hypoglycemic episodes in a two month period.
  c. Two or more hospitalizations for uncontrolled diabetes in a six month period.
  d. Any ketoacidosis or hyperosmolar state.
  e. Pregnancy in a previously diagnosed diabetic.
  f. Diabetics beginning initial insulin therapy.
- No coverage will be provided for initial training which exceeds ten hours, or for repeat training, without a prior authorization.

How to Code for DSME

Depending on the type of office visit, practices can use several CPT and ICD codes to bill for prediabetes screening and counseling. A list of commonly used CPT and ICD codes is included in this guide on page 12.

Importance of follow-up after a referral to DSME

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

- ***Medication*** – only 77 percent of patients with diabetes take insulin as prescribed and 85 percent take other medications as prescribed
- ***Monitoring*** – fewer than half – 45 percent – monitor their blood glucose as told
- ***Exercise and weight loss*** – only 24 to 27 percent of patients follow the instructions closely[10]

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

10 American Association of Diabetes Educators accessed at http://www.diabeteseducator.org/DiabetesEducation/Provider_Web_Pages/Importance_of_Follow-up.html

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)

Write your score in the box.

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)***

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.

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.

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

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

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

Visit us on Facebook
Facebook.com/AmericanDiabetesAssociation

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: 1-800-QUIT-NOW (1-800-784-8669).
- Ask all my providers to share my exam results with my other health care providers.
- Learn about managing my diabetes by visiting www.cdc.gov/diabetes/ndep
- Control my ABCs of diabetes:
  - **A1C**. This test measures average blood sugar levels over the last 3 months. The goal is less than 7% for many people but your health care provider might set different goals for you.
  - **Blood Pressure.** High blood pressure causes heart disease. The goal is less than 140/90mm Hg for most people.
  - **Cholesterol**. Bad cholesterol or LDL (Low Density Lipoprotein) builds up and clogs your arteries.

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

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.

NEVADA Wellness

NevadaWellness.org ■ **NVDiabetesEd.org**

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

Supported by the Nevada State Division of Public and Behavioral Health through grant number 3U58DP004820-02W1 from the Centers for Disease Control and Prevention.

Incorporate screening, testing and referral into practice

Sample patient flow process

MEASURE

CHECK-IN

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

ROOM/VITALS

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

ACT

EXAM/CONSULT

- Follow Standards of Medical Care in Diabetes – 2015, formerly Clinical Practice Recommendations
- Use the Diabetes Head to Toe Checklist Examination Report
- Advise on diet, exercise, and willingness to participate in DSME if diagnosed with diabetes
- If patient agrees to participate, proceed with referral

PARTNER

REFERRAL

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

FOLLOW UP

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





Point-of-Care: Diabetes Identification

(Excerpts from the abridged version of the American Diabetes Association Position Statement: Standards of Medical Care in Diabetes— 2015. Diabetes Care 2015;38(Suppl. 1): S1–S94.)

Criteria for the Diagnosis of Prediabetes and Diabetes

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

	Prediabetes	Diabetes
A1C	5.7–6.4%	≥6.5%
FPG	100–125 mg/dL (5.6–6.9 mmol/L)	≥126 mg/dL (7.0 mmol/L)
OGTT	140–199 mg/dL (5.6–6.9 mmol/L)	≥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]

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

Testing should be considered in adults who are overweight (BMI ≥25 kg/m^2 or ≥23 kg/m^2 in Asian Americans) and have additional risk factors:

- Physical inactivity
- First-degree relative with diabetes
- Hgh-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander)
- Women who delivered a baby weighing 9 lb or were diagnosed with GDM
- Hypertension (≤140/90 mmHg or on therapy for hypertension)
- HDL cholesterol level >35 mg/dL (0.90 mmol/L) and/or a triglyceride level >250 mg/dL (2.82 mmol/L)
- Women with polycystic ovary syndrome
- A1≥5.7%, IGT, or IFG on previous testing
- Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans)
- History of CVD

11 http://clinical.diabetesjournals.org/content/33/2/97.full.pdf+html

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

There are 4 critical times to assess, provide, and adjust DSME/S: (1) with a new diagnosis of type 2 diabetes, (2) Annually for health maintenance and prevention of complications, (3) when new complicating factors influence self-management, and (4) when transitions in care occur. Included below are the DSME/S Algorithm of Care and Algorithm: Action Steps. See, Powers et al, (2015, June 5). Diabetes Self-management Education and Support in Type 2 Diabetes: A Joint Position Statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics: *The Diabetes Educator OnlineFirst,* 1-14; for the complete guidance.

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

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

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

1	2	3	4
At diagnosis	**Annual** assessment of education, nutrition, and emotional needs	When new **complication 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 **complication factors** influence self-management	When **transitions** in care occur

Primary care provider/endocrinologist/clinical care team: areas of focus and action steps

• Answer questions and provide emotional support regarding diagnosis • Provide overview of treatment and treatment goals • Teach survival skills to address immediate requirements (safe use of medication, hypoglycemia treatment if needed, introduction of eating guidelines) • Make referral for DSME/S and MNT	• Access 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 *

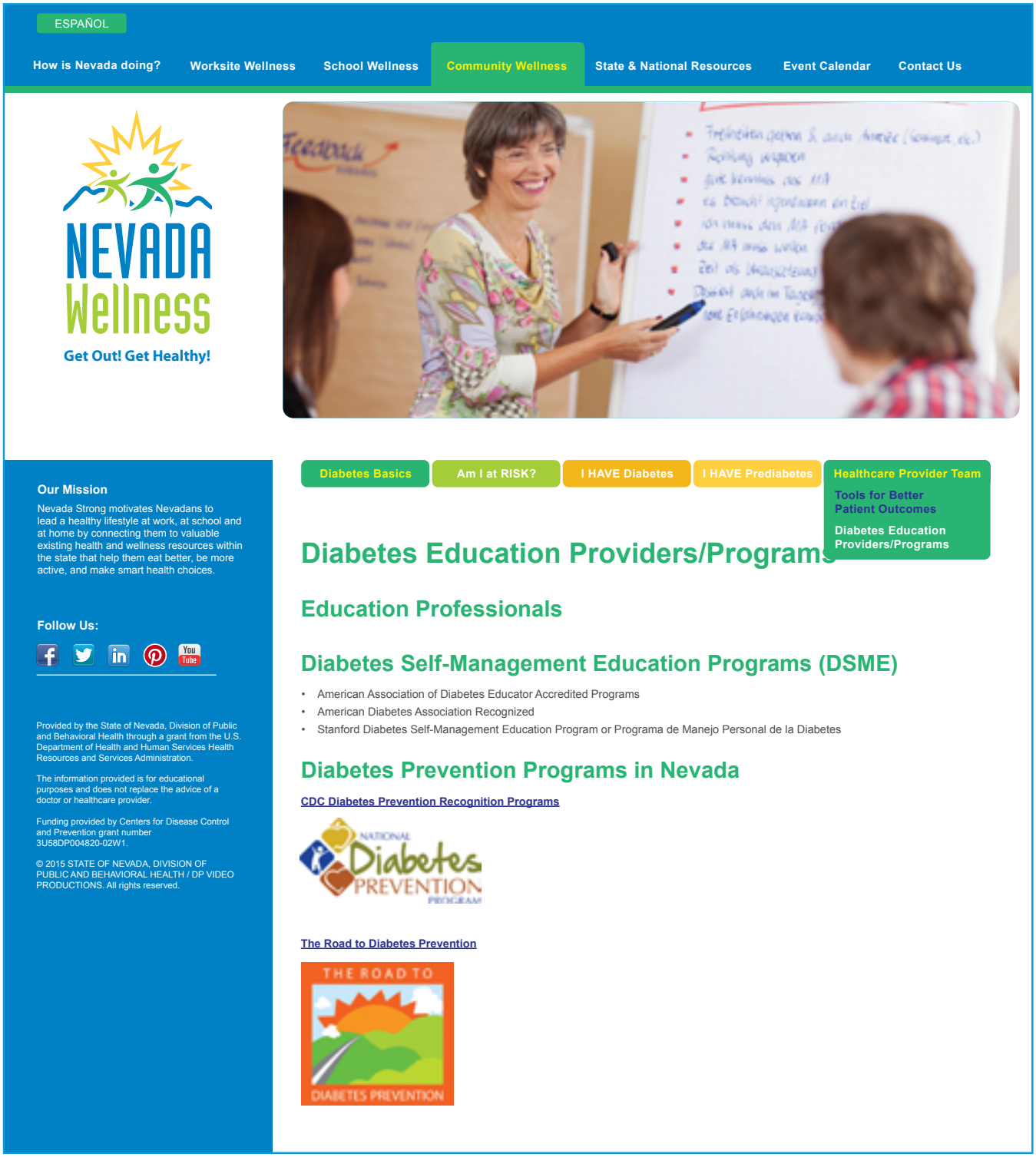
Assess cultural influences, health beliefs, current knowledge, physical limitations, family support, financial status, medical history, literacy, numeracy to determine content to provide and how: • Medications-choices, action, titration, side effects • Monitoring blood glucose - when to test, interpreting 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 cessations, 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.

Diabetes Self-Management in Nevada

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

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



Diabetes Self-Management Education/Training and Medical Nutrition Therapy Services Order Form

Patient Information

Patient's Last Name | First Name | Middle

Date of Birth _____/_____/_____ | Gender: ☐ Male ☐ Female

Address | City | State | Zip Code

Home Phone | Other Phone | E-mail address

Diabetes self-management education and training (DSME/T) and medical nutrition therapy (MNT) are individual and complementary services to improve diabetes care. Both services can be ordered in the same year. Research indicates MNT combined with DSME/T improves outcomes.

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

Check type of training services and number of hours requested

☐ Initial group DSME/T: ☐ 10 hours or ____ no. hrs. requested

☐ Follow-up DSME/T: ☐ 2 hours or ____ no. hrs. requested

☐ Telehealth

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

Check all special needs that apply:

☐ Vision ☐ Hearing ☐ Physical

☐ Cognitive Impairment ☐ Language Limitations

☐ Additional training ☐ additional hrs requested _____

☐ Telehealth Other _____

DSME/T Content

☐ Monitoring diabetes ☐ Diabetes as disease process

☐ Psychological adjustment ☐ Physical activity

☐ Nutritional management ☐ Goal setting, problem solving

☐ Medications ☐ Prevent, detect and treat acute complications

☐ Preconception/pregnancy management or GDM

☐ Prevent, detect and treat chronic complications

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

DIAGNOSIS

Please send recent labs for patient eligibility & outcomes monitoring

☐ Type 1 ☐ Type 2

☐ Gestational Diagnosis code _____

Complications/Comorbidities

Check all that apply:

☐ Hypertension ☐ Dyslipidemia ☐ Stroke

☐ Neuropathy ☐ PVD

☐ Kidney disease ☐ Retinopathy ☐ CHD

☐ Non-healing wound ☐ Pregnancy ☐ Obesity

☐ Mental/affective disorder Other _____

Medical Nutrition Therapy (MNT)

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

☐ Initial MNT ☐ 3 hours or ____ no. hrs. requested

☐ Annual follow-up MNT ☐ 2 hours or ____ no. hrs. requested

☐ Telehealth ☐ Additional MNT services in the same calendar year, per RD

Additional hrs. requested _____

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

_____

_____

_____

_____

_____

Medicare coverage: 3 hrs initial MNT in the first calendar year, plus 2 hrs follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis.

Definition of Diabetes (Medicare)

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

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

Source: Volume 68, #216, November 7, 2003, page 63261/Federal Register.

Other payors may have other coverage requirements.

Signature and NPI # _____ Date _____/_____/_____

Group/practice name, address and phone: _____

Revised 8/2011 by the American Association of Diabetes Educators and the American Dietetic Association.

Diabetes Head to Toe Checklist Examination Report

Your organization's name here_____

From: | **To:**

Patient Information:

Name: _____ **DOB:** _____

Diabetes: ❑ Type 1 ❑ Type 2 ❑ Gestational ❑ Prediabetes **HbA1c Goal:** _____ ❑ < 6 months ❑ >/= 6 months ❑ Unknown

Duration of Diabetes (in years): _____ **Current Diabetes Therapy:** ❑ Insulin ❑ Oral Hypoglycemic ❑ Diet Control ❑ None

Results of Last Finger-stick blood glucose reading (per patient): _____ ❑ N/A Patient reports under control ❑ Yes ❑ No

Dietary Counseling ❑ Yes ❑ No Type of Diet: _____

MEDICINES

Date: _____

Patient has a written med list ❑ Yes ❑ No

OTC Meds Used: (if none: ❑)

Herbal Meds Used: (if none: ❑)

Pharmacist reviewed meds on (date): _____

Patient has Rx for: (provide reason if "no")

Aspirin ❑ Yes ❑ No:

Cholesterol med ❑ Yes ❑ No:

ACE inh or ARB ❑ Yes ❑ No:

Reports Side Effects to Meds ❑ Yes ❑ No

If yes, describe:

Reports hypoglycemia events? ❑ Yes ❑ No

If yes, describe:

Does patient know their current:

A1c? ❑ Yes ❑ No Goal A1c?: ❑ Yes ❑ No

LDL? ❑ Yes ❑ No Goal LDL? ❑ Yes ❑ No BP? ❑ Yes ❑ No Goal BP? ❑ Yes ❑ No

Home Glucose Monitoring Frequency:

❑ once daily

❑ twice daily

❑ 3-4 times daily

❑ Other: _____

If on insulin, list current dose:

List dosing times:

KIDNEY/HEART & VASCULAR

Date: _____

Risk factors in addition to diabetes: (give dates for all)

Blood Pressure: Goal:_____ Measured: _____

Total, LDL and HDL cholesterol, triglycerides: (LDL goal and measured values for all)

_____

_____

Smoking status: (circle all that apply)

Never Former Current Willing To Quit

Assessments: (give dates for all)

Urine albumin-to-creatinine ratio: _____

Serum creatinine and estimated GFR:_____

_____

Potassium: _____

Hemoglobin: _____

History of myocardial infarction, heart failure, or stroke:_____

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

History of dialysis or kidney transplant:

_____

Kidney tests (ultrasound, CT Scan, Angiogram):_____

FEET

Date: _____

Current ulcer or history of a foot ulcer? ❑ Yes ❑ No

Foot Exam: Skin, Hair, and Nail Condition

Is the skin thin, fragile, shiny and hairless? ❑ Yes ❑ No

Are the nails thick, too long, ingrown, or infected with fungal disease? ❑ Yes ❑ No

Note Musculoskeletal Deformities

❑ Toe deformities ❑ Bunions (Hallus Valgus) ❑ Charcot foot

❑ Foot drop ❑ Prominent Metatarsal Heads

Pedal Pulses - "P" for present or "A" for absent

Posterior tibial Left__ Right__ Dorsalis pedis Left__Right__

Risk Categorization check appropriate box.

❑ **Low Risk Patient**	❑ **High Risk Patient**
All of the following:	One or more of the following:
❑ Intact protective sensation	❑ Loss of protective sensation
❑ Pedal pulses present	❑ Absent pedal pulses
❑ No deformity	❑ Foot deformity
❑ No prior foot ulcer	❑ History of foot ulcer
❑ No amputation	❑ Prior amputation

EYES

Date: _____

Visual Acuity (best corrected) Right:_____ Left:_____

Intraocular Pressure Right:_____ Left:_____

❑ **Dilated Fundus Exam Performed**

Diagnosis:

No Diabetic Retinopathy ❑ Yes ❑ No

Non-Proliferative Diabetic Retinopathy ❑ Yes ❑ No

Plan:

❑ Monitor Only ❑ Repeat Dilated Exam In _____ months

❑ Additional Testing/Treatment Recommended:

Proliferative Diabetic Retinopathy ❑ Yes ❑ No

Clinically Significant Macular Edema ❑ Yes ❑ No

MOUTH

Date: _____

Examination Findings

Intraoral/Extraoral:

Caries:

Periodontal (health, abscesses, gingivitis, periodontitis):

Xerostomia:

Fungal infection:

Parotid gland changes:

Functional (eating, swallowing, etc) concerns: _____

Additional Testing/Treatment Recommended: _____

Refer to Specialist: _____ Re-evaluate in _____months(s)

Management:

❑ Follow-up:_____ months ❑ Patient education/discussion ❑ Information pamphlet given

Referral To:_____ For:_____

Other_____ Doctor's Signature_____

BMI calculation chart

WEIGHT	100	110	120	130	140	150	160	170	180	190	200	210	220	230	240	250	260	270	280	290	300	310	320	330	340	350	360	370	380	390	400
HEIGHT																															
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)-9 for diabetes screening		**Current Procedural Terminology (CPT®) for diabetes screening tests**	
V77.1	Diabetes Screening	**CPT 82947**	Fasting Plasma Glucose Test
790.2	Abnormal Glucose	**CPT 82950**	Post-meal Glucose (2-hour plasma glucose; 2hPG; 2 hr specimen)
790.21	Impaired Fasting Glucose	**CPT 82951**	Oral Glucose Tolerance (3 specimens with 2 hr value included)
790.22	Impaired Glucose Tolerance (oral)	**CPT 83036**	Hemoglobin A1C
790.29	Other Abnormal Glucose NEC	**CPT 83036QW**	Hemoglobin A1C (used for POC test that is CLIA waived [~DCA])
278.00	Obesity		
278.02	Overweight		

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

References
* New York State Department of Health. New York State Diabetes Prevention Program (NYS DPP) prediabetes identification and intervention algorithm. New York: NY Dept of Health; 2012.
† American Diabetes Association. Standards of medical care in diabetes—2013. Diabetes Care. January 2013; 36:S11-66. doi: 10.2337/dc13-S011
‡ Ackermann RT. Coding Guide for Diabetes and Prediabetes Testing. 2013. (Published here with permission from Ronald T. Ackermann MD, MPH.)

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is to maximize the health of Nevadans by improving policy, systems and environment
that influence quality of life.