Primary Care Symposium
Diabetes Management Session

Dr. Shahed Quyyumi- Endocrinologist
Debra Marotta- Certified Diabetes Educator/ Nurse Manager at Staten Island University Hospital
Diane Arneth- Executive Director of Community Health Action of Staten Island
Ava Blair- Registered Nurse at Coordinated Behavioral Care

DECEMBER 2, 2017
2:00 P.M.-3:15P.M.
Review of Diabetes Mellitus

Shahed Quyyumi  M.D.
Definition

- Fasting glucose >126 mg./dl.
- Random glucose >200 mg./dl
- HB A1C 6.5
- A1C can be unreliable in patient’s with hypoglycemia, especially Type 1 Diabetes.
- Anemia, ethnicity, and hemoglobinopathies can give spurious results, always correlate with recent fingerstick glucose levels.
Definition

• Type 1: generally autoimmune, 50 percent new cases can present in adulthood. Generally not obese.

• Consider checking C-peptide levels if doubt exists.

• Type 2: strong genetic basis, inherited from maternal mitochondria. Obesity is very common.
Drug induced Diabetes

- Glucocorticoids, progesterone therapy for contraception, and appetite stimulation.
- Beta blockers, thiazide diuretics can worsen diabetes control
- Immunosuppressants
- If possible avoid medications that cause weight gain.
Obesity

• Consider weight loss drugs, and or diabetes meds that promote weight loss.
• Refer for diabetes education/dietary consult.
• Obesity impacts on many other health issues.
Diabetes Complications

• Microvascular- retinopathy, neuropathy, nephropathy.
• Severity of complications strongly depends on diabetes control.
• Control of hypertension is very important, especially with A.R.B.’s and A.C.E. inhibitors.
• No therapy available for diabetic nephropathy or neuropathy
Macrovascular complications

• Antidiabetic therapy has not been shown to improve vascular outcomes, except for empagliflozin (Jardiance), and liraglutide (Victoza).
• Aggressive diabetes control can significantly improve hypertriglyceridemia.
• Always look at non hdl-cholesterol measurements, (goal < 100 for high risk patients.)
The Future

• Non invasive (continuous glucose monitoring), especially for Type 1 Diabetes.
• “Smart” insulin pumps that autonomously control glucose levels in Type 1 diabetes.
• Implantable exenatide pump for type 2 diabetes.
• Oral Glp-1 agonists.
THANK YOU
Diabetes Self-Management Program

Staten Island University Hospital
Northwell Health
Debra Marotta, MSN, RN, CDE
The Diabetes Self-Management Program

The Diabetes Self Management Program (DSMP):

❖ is a nationally recognized American Diabetes Association (ADA) program.
❖ empowers patients through:
  ❖ evidence based diabetes education.
  ❖ individual sessions or small groups in English, Spanish and Arabic.
  ❖ facilitating knowledge, skills, and ability necessary for diabetes self-care.
  ❖ assisting in implementing and sustaining the behaviors needed to manage diabetes on an ongoing basis.
ADA programs are structured to meet the ten national standards for diabetes self-management education & support. The program structure is designed to:

❖ define the quality of the program.
❖ assist those who provide diabetes education with evidence-based diabetes educational criteria.
The DSMP’s goals are to provide a coordinated team-based approach to encourage patients to:

❖ taking charge of their health.
❖ increase confidence and skills in managing their daily diabetes care.
❖ preventing or delaying complications associated with diabetes.
❖ decreasing ED and hospital visits.
The DSMP’s core curriculum:

❖ is the ADA’s evidence-based foundation from which the appropriate content is drawn to build an individualized education plan based on each participant’s concerns and needs.

❖ specifies effective teaching strategies and methods for evaluating learning outcomes.

❖ reflects recent education research.

❖ endorses practical problem-solving approaches and collaborative care.

❖ addresses psychosocial issues, behavior change, and strategies to sustain self-management efforts.
DSMP’s CORE CURRICULUM

Content:

❖ good nutrition
❖ being active
❖ stress reduction
❖ monitor blood glucose
❖ medication adherence
❖ managing acute and chronic conditions
❖ diabetes and pregnancy
❖ practicing proper foot, skin, eye and dental care
❖ effectively utilizing available health systems and community resources
Coordination between the DSMP and the primary care provider is critically important for the patient’s safety and wellbeing. This communication assists the patient in achieving their health care goals and live a healthy and fulfilling life.
The DSMP’s 2016 annual status outcomes reported to the ADA (n=242):
   ✦ DSMP satisfaction, experiences with program - 91%.
   ✦ Behavioral outcome - 80% (blood glucose monitoring).

Total program participation:
   ✦ Jan to Sept 2016 - 151
   ✦ Jan to Sept 2017 - 368
     ✦ 2017 increased Medicaid participation by 10%
Diabetes Self - Management Team

Management Team:

Debra Marotta, MSN, RN, CDE
Marci Kliesch, RD, CDE
Karla Yanes, RN, Diabetes Educator
Nicole Lutz, MSN, RN, Diabetes Educator
Raghda Alraei, DCN, MS, RD, CDE
Ketzia Betancourt, Secretary

As a team we work hand and hand with the patient’s health care providers to provide the patient with a powerful diabetes self-management patient experience.
Program Information

Location: 242 Mason Ave, SINY 10305
2nd floor Suite 6 A

Phone: 718-226-1547
Fax: 718-226-6150

e-mail: dmarotta@northwell.edu


Staten Island PPS Primary Care Symposium:
Diane Arneth
Diabetes Management

December 2, 2017
Community Health Action of Staten Island drives dramatic improvements in the health of Staten Islanders.
What keeps us up at night?

- 1 in 4 Medicare patients over 65 do not take their BP meds as prescribed (CDC)
- 20-30% of prescriptions written for chronic health conditions not filled (CDC)
- Nonadherence accounted for an estimated 125,000 deaths annually (ACPM)
- Costs estimated at $300 BILLION a year (Johns Hopkins)
“Being a patient, especially a patient with a chronic condition, is a lot of work.”

Victor Montori, M.D.
Professor of Medicine, Mayo Clinic
“Doctors are the only people on the planet who have the idea that you can tell people, ‘Here, work on this every day and I’ll see you in two or three months’.”

Victor Montori, M.D.
Professor of Medicine, Mayo Clinic
So,

What to do?
Stanford Self-Management programs are designed to complement and enhance traditional clinical treatment and disease specific education programs.

- Evidence-based workshops developed by [Stanford University’s Patient Education Research Center](http://www.stanford.edu)
- Goal is to develop skills needed in the day-to-day management of chronic health conditions
- Six highly interactive weekly sessions focused on sharing experiences and skills-building
- Workshops facilitated by trained Peer Leaders or Master Trainers in pairs
- Two Cohorts: Chronic Disease Self-Management and Diabetes Self-Management
Diabetes Self Management Program

Stanford Diabetes Self-Management Program (DSMP) Workshop for people with type 2 diabetes

• teaches skills needed in day-to-day management of diabetes and to maintain and/or increase life’s activities

• supports participants in developing skills needed in the day-to-day management of type 2 diabetes

• supports self-managed behavior modification and coping strategies to manage type 2 diabetes, food choices, medications, and increased physical activity levels.
CHASI Program

• Conduct both CDSM and DSM

• Funded by Robin Hood Foundation and Staten Island PPS

• Trained 25 peer facilitators from the community as trainers

• Graduated 382 participants over last 3 years

• 90% of participants graduate program
Some Promising Trends Seen Among Participants

Six Month Trends for Cohort

• Small reduction in Hgb A1C
• Small reductions in systolic and diastolic pressure
• Reduction in emergency room use
• Reduction in depression screen scores

Sustainability

• Clinical markers variable
• Depression, ED and hospitalization reductions more sustainable
<table>
<thead>
<tr>
<th>Blood Pressure (average systolic/average diastolic) **</th>
<th>Baseline</th>
<th>6- Month</th>
<th>12-Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 1, 2014 - September 30, 2015</td>
<td>143.3/88.87</td>
<td>133.43/82.52</td>
<td>132.91/85.5</td>
</tr>
<tr>
<td>October 1, 2015 - September 30, 2016</td>
<td>141.48/89.79</td>
<td>130.95/82.15</td>
<td>129.58/81.08</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A1C *</th>
<th>Baseline</th>
<th>6- Month</th>
<th>12-Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 1, 2014 - September 30, 2015</td>
<td>7.93</td>
<td>7.87</td>
<td>7.9</td>
</tr>
<tr>
<td>October 1, 2015 - September 30, 2016</td>
<td>8.31</td>
<td>8.22</td>
<td>8.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Depression Score</th>
<th>Baseline</th>
<th>6- Month</th>
<th>12-Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 1, 2014 - September 30, 2015</td>
<td>7.65</td>
<td>6.11</td>
<td>5.47</td>
</tr>
<tr>
<td>October 1, 2015 - September 30, 2016</td>
<td>6.48</td>
<td>5.73</td>
<td>5.57</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Room Visits</th>
<th>Baseline</th>
<th>6- Month</th>
<th>12-Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 1, 2014 - September 30, 2015</td>
<td>1.59</td>
<td>0.74</td>
<td>0.58</td>
</tr>
<tr>
<td>October 1, 2015 - September 30, 2016</td>
<td>0.59</td>
<td>0.49</td>
<td>0.74</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospitalizations</th>
<th>Baseline</th>
<th>6- Month</th>
<th>12-Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 1, 2014 - September 30, 2015</td>
<td>0.29</td>
<td>0.18</td>
<td>0.09</td>
</tr>
<tr>
<td>October 1, 2015 - September 30, 2016</td>
<td>0.2</td>
<td>0.1</td>
<td>0.13</td>
</tr>
</tbody>
</table>
CHASI workshops are held in the community at CBOs, libraries and our community food pantry.

We are happy to provide your practice with information about the program and community schedules.

If you have 10-15 patients who could benefit from this, let’s talk!
Diane Arneth
Executive Director
Community Health Action of Staten Island
Chief, Community Services Officer
Brightpoint Health
718.808.1401 | diane.arneth@chasiny.org
Facebook.com/CommunityHealthAction
Health Home
Diabetes Management

STATEN ISLAND PERFORMING PROVIDER SYSTEM
PRIMARY CARE SYMPOSIUM
DECEMBER 2ND, 2017
Coordinated Behavioral Care

- CBC is a not-for-profit organization launched in 2011 by many of New York City’s leaders in medical, behavioral health, rehabilitation and supportive housing service systems.

- CBC is dedicated to improving the quality of care for members and their families, while reducing potentially preventable inpatient and emergency services use by people with serious mental illness, chronic health conditions and/or substance use disorders.

- CBC aims to ensure that all members receive the needed services in their community in the most expeditious and appropriate manner.

- CBC assists the Behavioral Health community through direct support and advocacy for the maintenance and strengthening of the service delivery system as the shift to managed care and integrated care take hold.
Health Home

What is it?

• A Health Home is not a physical location...It is a care management model
• A Health Home consists of a network of providers, including medical, mental health and substance abuse, which form an integrated system of care
• The Health Home takes primary responsibility in assuring that members’ healthcare and social needs are met.
Health Home

How is it useful?

- Reduces preventable emergency room and inpatient stays
- Improves outcomes for persons with mental health and/or substance use disorders
- Improves disease-related care for chronic conditions
Care Management

- Holistic approach: Encompasses medical care, behavioral care and social determinants of health
- Efficacy measured by outcomes (e.g. reduced hospital admissions and ER visits)
- Plan of Care is formed that includes input from the entire care team
- Service intensity determined by need rather than regulation
- Utilizes informed decision-making and personalized interventions
Care Management with Diabetes

Focus on education and assisting the diabetic person to develop the skills to:

◦ Understand the disease
◦ Complete self-care and monitoring
◦ Cope with emotions
◦ Work with medical providers to support managing medications
◦ Work with health care providers
◦ Set and follow through on goals
◦ Make action plans for exercise and healthy eating

Care managers set the tone by interacting with primary care providers to facilitate care
Diabetic Members at CBC

- CBC has 16,805 members enrolled in Care Coordination Services
  - **Youngest:** 2 months, born 7/17/2017
  - **Oldest:** 102 years old, born 4/8/1915
- > 3K enrolled members identified as having diabetes
- > 10K enrolled members identified as having mental health conditions
- Among diabetic enrollees heart disease is the most frequent co-occurring diagnosis
- CBC is participating in the SDOH-PAM program to assist diabetic members to become involved in their care and take more ownership of their health
Health Promotion at CBC

Managed Care Partnerships

- CBC disseminates Gaps in Care reports from MCOs including diabetes-specific HEDIS measures.
- CBC and MCOs partner in Complex Case Conferences to review challenging cases.
- Medicaid Member Incentive programs- for members who complete yearly diabetic exams.

2017 Trainings

- CBC offers web-based Diabetes Basics and Care training through its resource center.
- CBC offers referrals to Bronx Partners for Healthy Communities.
**Improved Outcomes**

Diabetic enrollees experience:

- Fewer hospitalizations
- More scheduled primary care visits
- Better understanding of their disease state
- Greater satisfaction with their care
Presented by Ava Blair RN BSN
ablair@cbcare.org
For CBC Health Home
Thank you