A Collaborative Approach to Diabetes Care III

Reducing Readmissions & Costs while exceeding in Patient Care Across the Healthcare Continuum

Diabetes is now considered a global epidemic and leading chronic disease with a high burden of cost and loss of quality of life. Most costs associated with diabetes care are related to the management of its chronic complications.

DISTINGUISHED SPEAKERS INCLUDE:

Jane Jeffrie Seley  
Diabetes Nurse Practitioner  
New York Presbyterian/Weill Cornell

Caroline B. Isbey  
Associate Director-Disease-Specific Care Certification  
The Joint Commission

Carol Manchester
Diabetes Clinical Nurse Specialist  
University of Minnesota Medical Center, Fairview

Barbara Walters, DO  
Dartmouth-Hitchcock Hospital

Susan Lehrer  
Associate Director of Care Management  
New York City Health Hospitals Corporation

Katherine Brieger  
Executive Director of the HRH  
Care Planetree Institute

Donna Zazworsky  
Vice President, Community Health & Continuum Care  
Carondelet Health Network

Rich Davis, MD  
Lead Research Navigator, NC TraCS Institute  
UNC Center for Diabetes Translation Research

KEY ISSUES DISCUSSED:

- Improving quality for patients with diabetes through The Joint Commission Certification
- The Endocrine Society Guidelines for the management of hyperglycemia in the non-critical care setting.
- Understand the changing role of the care coordinator as the regulations associated with the Affordable Care Act are implemented.
- Understand how Federally Qualified Health Centers are working to improve diabetes care coordination.
- Developing a collaborative model of care that allocates resources to manage illness burdens, gaps in care and care plans of a defined patient population.
- Strategies for patient-based approach to inpatient education, including teaching basic survival skills as well as discharge planning.
- Identify national guidelines, standards and recommendations that support best practice for Peri Operative Glycemic control.
- Standards of education for: hospital administration, physicians and nursing staff.
- Telehealth: hybrid healthcare for improved outcomes.
- Current and emerging technologies in diabetes care.
- Advancing continuing care outcomes while advancing the provisions of quality & cost effective care throughout the continuum of care

This activity has been submitted to the Wisconsin State Nurses Association for the approval to award contact hours. The Wisconsin State Nurses Association is accredited as an approver of continuing nurses education by the American Nurses Credentialing Center's Commission on Accreditation.

Tampa, FL    October 24-25, 2014

FOR REGISTRATION DETAILS

call 414-255-9525  or email:gbosch@currentadvantage.com
REGISTRATION - DAY ONE

8:00am-9:15am
SMOOTHING THE TRANSITION FROM HOSPITAL TO HOME: HOW TO PREVENT READMISSIONS IN PATIENTS WITH HYPERGLYCEMIA

This study will reveal why meeting the endocrine society guidelines for inpatient Glycemic control will help prevent 30 day readmissions. The Endocrine Society Guidelines for the management of hyperglycemia in the hospital setting will be reviewed. Barriers to achieving inpatient Glycemic targets will be discussed, as well as possible solutions. An overview of best practices that facilitate smooth care transitions from inpatient to outpatient will be highlighted.

ATTENDEES WILL LEARN:
• An overview of the Endocrine Society Guidelines for the management of hyperglycemia in hospital patients in the non-critical care setting.
• Barriers to achieving inpatient Glycemic targets and possible solutions.
• Best practices that facilitate smooth care transitions from inpatient to outpatient.
• Inpatient Insulin Pump Therapy - Can patients wear their insulin pumps safely in a hospital setting?

Jane Jeffrie Seley DNP MPH BC-ADM CDE CDTC
Diabetes Nurse Practitioner
New York Presbyterian/Weill Cornell

Ms. Seley is an active speaker and consultant whose commitment to professional diabetes education is second only to her dedication to delivering the best clinical care for people living with diabetes. Ms. Seley holds a Masters degree in Gerontological Nursing (MSN) from Hunter-Bellevue School of Nursing and a Masters degree in Public Health (MPH) from New York University. Among her vast accomplishments, Jane serves as the New York City Programs Director for MNYADE and is Chairman of the AADE Inpatient Diabetes Specialty Practice Group. Ms. Seley serves as a Member of its New York City Leadership Council and Member of the ADA’s New York City Leadership Council. She is a contributing editor and column coordinator of the ‘Diabetes Under Control’ column in the American Journal of Nursing, Nursing Editor for Present Diabetes and the National Academies of Practice.

9:15am-10:15am
COORDINATION ACROSS EACH TRANSITIONS OF PATIENT CARE: A FOCUS ON THE PATIENT DIAGNOSED WITH TYPE 2 DIABETES

The silos that exist in today’s healthcare delivery negatively impact a patient’s ability to understand their diagnosis, what they need to do to achieve the goals they strive to achieve and the benefits of following a chronic disease management plan. With implementation of ACA and the regulations spawned from that legislation, the measures that define quality healthcare delivery are changing. As we assist the patient and their support systems to navigate the vital components of chronic disease management, we are charged with not only considering the process of care but also advancing patient adherence and persistency, patient satisfaction and the attainment of consumer-driven healthcare goals. This program will focus on the care coordination pathways that assist the patient to move toward the achievement of those goals across and through each transition of patient care and each encounter with a healthcare professional.

OBJECTIVES OF PRESENTATION HIGHLIGHTS:
• Define the role of the care coordination team with a focus on the patient with Type 2 Diabetes.
• Discuss the successful “hand-over” of a patient with a chronic disease such as Diabetes as the patient navigates the sometimes confusing system that facilitates their care.
• Discuss the definitions of care coordination, transitions of care, disease management, and a chronic disease continuing care map.

ATTENDEES WILL LEARN HOW TO:
• Develop a care coordination team that advances the delivery of quality healthcare interventions with no exclusions but with an expectation for patient engagement, empowerment and education.
• Recognize “competencies” that advance desired continuing care outcomes while advancing the provision of quality and cost-effective care through the healthcare continuum.
• Understand the changing role of the care coordinator as the mandates and regulations associated with the Affordable Care Act are implemented.

Nancy Skinner RN-BC, CCM
Riverside HealthCare Consulting

Nancy has for the past 25 years served as a national case management educator. In her current role as principal consultant for Riverside HealthCare Consulting, she develops programs that advance excellence in care coordination and other transitional care strategies. In 2002, she was named the Case Management Society of America (CMSA) National Case Manager of the Year and in 2008, she received CMSA’s Lifetime Achievement Award. She currently serves as President of the Case Management Society of America and is a Board Member of the Hospital Quality Foundation. Additionally, she assisted in the development of Post-Discharge Standards for Cardiovascular Disease for the Society of Chest Pain Centers and is co-author of the Case Management Adherence Guidelines for Diabetes. Nancy is an Advisory Task Force Member of the National Transition of Care and serves as primary faculty for the University of Southern Indiana Case Management Certificate Course.
10:15am-10:30am
BREAK

10:30am-11:30am
COMMUNITY CONNECTIONS IN DIABETES CARE COORDINATION: IMPROVING OUTCOMES THROUGH PRIMARY CARE

Care coordination within the primary care setting can impact outcomes, reduce unnecessary hospitalizations and ER use. Participants will learn about the impact of diabetes care coordination, in a Federally Qualified Health Center, and its impact on at risk patients. Team based care coordination will be described in detail, outlining different roles and training of staff to improve health outcomes, with lower costs. Participants will become familiar with how an ACO (Accountable Care Organization) can impact the quality of care received by patients with diabetes. This presentation will include information on how a cross section of healthcare organizations are able to coordinate care, and reduce costs as well.

ATTENDEES WILL LEARN:
• To work with primary care practices to improve hospital readmissions, unnecessary ER use.
• To understand how Federally Qualified Health Centers are working to improve care coordination.
• To utilize care team members, both internal/external, to improve health outcomes.

Katherine Brieger, MA, RD, CDE
Executive Director of the HRHCare Planetree Institute

As Executive Director of the Planetree Institute Ms. Brieger is the director of all activities for training and staff development as well as diabetes related grants, programs, are transitions and patient engagement programming. As Chief Operations Officer she oversees all operations and nursing oversight for 16 sites within HRHCare. As VP of community initiatives for Hudson River Health she manages all aspects of patient care and delivery of medical and mental health services at 3 sites as well as directing all aspects of staff training and health education activities. Currently she is working on a grant with New York Health Foundation and Health Center Network to have several FQHCs recognized in the diabetes recognition program of NCOA. Ms. Brieger has presented several national lectures on diabetes management and care coordination's/PCMH/Special populations. She has provided information on several articles regarding care coordination in the area of diabetes management. She has extensive experience working in developing and teaching patient self management goals and has written many articles on proper nutrition and health living.

11:30am-12:30pm
POPULATION HEALTH MANAGEMENT TOOLS FOR ACO: TECHNOLOGIES & TACTICS TO SUPPORT ACCOUNTABLE CARE

Excellence in population health management can only be achieved through experience. CMS Physician Group Practice participant Dartmouth-Hitchcock has developed a competency in population health management that it deploys in ongoing ACO pilots with Medicare and Cigna and in an ACO pilot in development with Anthem/WellPoint. Dartmouth-Hitchcock senior medical director Dr. Barbara Walters shares how the pilots have demonstrated the value of an ACO by achieving efficiency, quality and cost targets. The pilot examines the building blocks of population health management that drive improvements in healthcare quality and efficiency in ACOs — while positioning healthcare organizations for core measure improvement and increased reimbursement. One such building block is an effective patient registry, which provides usable, actionable data — a true snapshot of the patient population being served and for which the organization is accountable. A registry also keeps organizations on track with recommended care and identifies ways to improve outcomes.

ATTENDEES WILL LEARN:
• The shared savings and total cost of care payment methodology developed by Dartmouth and Cigna for commercial members attributed to Dartmouth;
• The new roles and responsibilities within an ACO to efficiently manage the health of a population, including strategies for practicing at the top of license;
• Developing a collaborative model of care that allocates resources to manage illness burdens, gaps in care and care plans of a defined patient population; and
• Results from Dartmouth’s ACO pilots with CMS and Cigna, including where Dartmouth has achieved better than market results or these programs.

Dr. Barbara Walters
Senior Medical Director
Dartmouth-Hitchcock Hospital

Dr. Walters is the Executive Medical Director at Dartmouth-Hitchcock and Chief Medical Officer for OneCare Vermont. In this role she is responsible for strategy, oversight and implementation of Population Health Care Delivery and Accountable Health Care Model as part of the leadership team. Prior to this she was the Senior Medical Director for the Community Group Practices of Dartmouth Hitchcock with operational and profit-and-loss responsibility for the organization's ambulatory sites. These are 18 sites with $300 million in revenue, 1 million visits per year, and 1,800 staff, including 400 providers. Areas of responsibility include commercial contracting, information technology oversight, quality improvement, evidence-based practice, population health, Regional Primary Care Coordinating Committee, strategic plan oversight, Clinical Transformation Governance Group, and principal investigator for the CMS Physician Group Practice Demonstration Project. She currently is the executive charged with leadership for the Pioneer ACO and Dartmouth Hitchcock Wellness.Plus, the employee health plan service. Prior to joining Dartmouth-Hitchcock, Dr. Walters served as medical director at different levels at the Carolina-Permanente Medical Group, Raleigh, NC. She began at the group as Chief of Mental Health Services in 1989. Prior to that organization, she was a psychiatrist at the Kaiser and Wake Mental Health Center in Raleigh, NC. Dr. Walters received her undergraduate degree from Wayne State, Detroit, Michigan. She received her DO from Michigan State University; did her internship at Lansing General Hospital; and completed her residency at University of North Carolina Chapel Hill. She also holds an MBA from Duke University Fuqua School of Business.
ATTENDEES WILL LEARN HOW TO:

- Incorporate elements of the Diabetes Continuum of Care that integrates diabetes educators and navigators into a systems approach with primary care practices, out-patient diabetes self-management programs, diabetes day clinics, and telehome technology.
- Define the innovative reimbursement structures to support this new systems approach with a Medicaid health plan.
- Identify the importance of a Diabetes Scorecard that links improved diabetes outcomes to cost savings.
- Incentivize structures of a new payment model to support provider and health plan participation.

Donna Zazworsky, RN, MS, CCM, FAAN
Vice President, Community Health and Continuum Care
Carondelet Health Network

Donna Zazworsky is Vice President for the Community Health and Continuum Care division for Carondelet Health Network, a faith-based integrated healthcare network covering Pima, Santa Cruz and Cochise counties in Arizona. She is responsible for integrating and bridging health promotion, chronic care and transitional care across acute care, outpatient, primary care and community partnerships. Ms. Zazworsky provides direct oversight of the network’s Diabetes Continuum of Care, Transitional Care, Telehealth services and Southern Arizona Health Village for the Homeless. These services address innovative delivery models in caring for the uninsured, underserved and vulnerable populations.

Ms. Zazworsky has authored numerous articles and chapters on case management, disease management, caring for the uninsured/underserved and advanced practice nursing.

She was the lead editor and author of The Handbook of Diabetes Management, a resource textbook for community health providers published by Springer. Most recently, she authored a chapter on Carondelet’s Community-based Care Transitions in the 2013 ANA book: Care Coordination, The Game Changer. Ms. Zazworsky is an adjunct Clinical Associate Professor at the University of Arizona, College of Nursing. She also serves on the local Catholic Community Services Board, Mercy Care Plan Board and the American Diabetes Association Board of Southern Arizona and nationally on the National Kidney Foundation Advisory Board. Ms. Zazworsky has received numerous community and professional awards for her expertise and service. Most recently, she was named as one of Tucson’s ten Women of Influence and received Carondelet’s first President’s Award.

2:30pm-2:45pm
BREAK

GUIDELINES TO EFFECTIVELY MANAGE PERIOPERATIVE GLYCEMIC MANAGEMENT

The area of Glycemic management for the entire Perioperative phase of care is still very much in the spotlight. Savings can be obtained by reducing infection and mortality risk with optimal control, guidelines in place to manage effectively throughout the Perioperative experience and guidelines that assist providers in determining when cases should be delayed or postponed.

ATTENDEES WILL LEARN:

- To identify current practice in Perioperative Glycemic control.
- To identify national guidelines, standards, and recommendations that support best practice in the hospital.
- To identify key strategies that can be utilized to implement the evidence, ensuring delivery of safe and effective Peri Operative care.

Carol Manchester, MSN, ACNS, BC-ADM, CDE
Diabetes Clinical Nurse Specialist
University of Minnesota Medical Center, Fairview

Ms. Manchester has been dedicated to diabetes care, education, and practice for many years. Clinical activities include consultation, education, and research. As the co-chairperson of the University of Minnesota Medical Center Acute Care Diabetes Advisory, she is responsible for clinical excellence and quality for clients with hyperglycemia. As an adjunct faculty member of the University Of Minnesota School Of Nursing, she lectures undergraduate and graduate students on endocrine related disorders and chronic disease management. Additionally, her precepts graduate students in the clinical nurse specialist program who are interested in diabetes as a subspecialty of adult health. She is a published author, and has lectured extensively on diabetes related topics including acute care Glycemic management. Current research includes the second phase and continuation of a qualitative exploratory study “A Human Factors System Analysis of Medication Errors” conducted in collaboration with the critical care CNS and 2 faculty members from the Center for Human Factors, Univ. of MN School of Design. Two collaborative studies on Glycemic management are underway.
A JOURNEY TOWARD BETTER GLYCEMIC CONTROL IN THE HOSPITALIZED PATIENT

Hyperglycemia is common in the hospitalized patient and improved glycemic control has been shown to improve clinical outcomes. There are many known benefits; however, two primary benefits are decreased risk of infection and decreasing the length of stay. Our hospital was able to decrease patient length of stay by 0.17 days in the first eighteen months of the project. This seemingly small reduction has a potential revenue increase of $244,375. This can also lead to a cost avoidance of $946,421. Using evidence-based practice has overall reduced the percent of hyperglycemia without increasing the risk of hypoglycemia.

OBJECTIVES OF PRESENTATION HIGHLIGHTS:
- Importance of education to: Hospital Administration, physicians, and nursing staff.
- Following standards for evidence-based medicine in relation to basal/bolus/correction and discontinuing oral antihyperglycemic medications on admission.
- Importance of a multidisciplinary team and biweekly committee meetings.

ATTENDEES WILL LEARN HOW TO:
- Tool to educate the physicians and nurses for better glycemic control.
- Developing tools for better education for patients.
- Data collection.

Dee Brown MSN, RN, CDE
Nursing Staff Development, Diabetes Nurse Educator – In-Patient and Outpatient Diabetes Program Coordinator
Virginia Hospital Center

In her role as Diabetes Educator Dee manages a budget for the outpatient program and five clinical professionals including nurses, dietitians, occupational therapist and administrative personnel. She maintains all financials within budget and provides efficient and effective leadership. She is responsible for the designed curriculum for outpatient diabetes basic program class. She provides direct oversight in the recruiting, selection, hiring, and day-to-day mentorship of assigned clinical personnel while ensuring program compliance with the American Diabetes Association national standards for Diabetes Education. Dee assesses patients and has developed individual care plans for all aspects of diabetes care to include family familiarization and awareness. In doing so, Dee developed an in-patient survival skills booklet, started a Diabetes Resource Nurse committee with representatives from each nursing unit, developed Diabetes Resource nurse training seminars, and provides nursing and physician in-service related to diabetes and annual competencies such as blood glucose meters. She is responsible for leading a multidisciplinary team in reducing hyperglycemia in the hospitalized patient without increasing hypoglycemic events. Dee also organizes free community events to increase awareness during Diabetes Awareness month.

4:45pm
END OF CONFERENCE - DAY ONE

CONFERENCE - DAY TWO

8:00am-9:30am
JOURNEY TO IMPROVING QUALITY OF CARE FOR PATIENTS WITH DIABETES THROUGH JOINT COMMISSION CERTIFICATION

When considering quality of care for patients with diabetes, implementing the core requirements to achieve certification provides the road map to decrease variability in care and improve outcomes for this patient population. The core requirement consist of structuring the care program to meet The Joint Commission Disease-Specific Care certification standards, utilizing Clinical Practice Guidelines/Recommendations to guide the are being provided and engaging the Performance Improvement process by defining, tracking, analyzing data and creating a PI plan from a minimum of 4 Performance Measures. Additionally, the additional clinical requirements for diabetes care in the inpatient setting which have been demonstrated to achieve certification, also assists in decreasing the variability of care and leads to improved quality of care. An explanation of these requirements will be provided.

ATTENDEES WILL LEARN:
- To identify how the process of certification improves Quality of Care.
- Five Inpatient Diabetes Care Specific requirements.
- To identify three core components to DSC Certification.
- To Identify three benefits of certification.

Caroline Isbey is the associate director for the Disease-Specific Care Certification program at The Joint Commission. In this role, she assists with oversight of all certification activities related to disease management services, including the development of standards and review processes. Ms. Isbey has 26 years of nursing, with a focus in cardiovascular nursing, diabetes management, and diabetes program management. She most recently served as Director of Clinical Operations in the Hospital Division at Healthways, Inc. in Nashville, TN, a national disease management provider. Ms. Isbey is a certified diabetes educator. She earned her master’s degree as a Clinical Nurse Specialist and her bachelor’s degree in nursing from University of North Carolina - Charlotte.
INPATIENT DIABETES EDUCATION IS ASSOCIATED WITH LESS FREQUENT HOSPITAL READMISSION AMONG PATIENTS WITH POOR GLYCEMIC CONTROL

Hospital readmission is a major target of healthcare quality-improvement efforts. Since October 2012, hospitals have had their Medicare reimbursement cut if their 30-day readmission rates for pneumonia, heart failure, and heart attacks exceed a certain threshold. It is expected that other conditions will be added, Dr. Healy noted in her presentation. Formal inpatient diabetes education was associated with a reduction in the rate of hospital readmission for patients with poorly controlled diabetes, a new study has found. The objective of the study was to explore the relationship between inpatient diabetes education (IDE) and hospital readmissions in patients with poorly controlled diabetes. A retrospective study of patients with poorly controlled diabetes (HbA1c>9%) hospitalized between 2008 and 2010. In all, 2,265 patients were included in the 30-day analysis and 2,069 patients were included in the 180-day analysis. Patients who received IDE had a lower frequency of readmission within 30 days than did those who did not. This relationship persisted after adjustment for sociodemographic and illness-related factors. The conclusion of the study was that formal IDE was independently associated with a lower frequency of all-cause hospital readmission within 30 days; this relationship was attenuated by 180 days.

OBJECTIVES OF PRESENTATION HIGHLIGHT:
- Discuss the association between IDE and hospital readmissions as described in this retrospective study.
- Discuss other predictors of readmission that were identified in the study.
- Discuss strategies for a patient-based approach to inpatient diabetes education, including teaching basic survival skills as well as discharge planning.

ATTENDEES WILL LEARN HOW TO:
- Identify patients with diabetes who may be at risk for readmission by the predictors noted in the study.
- Incorporate diabetes education during the hospital stay for patients with poorly controlled diabetes.
- Teach & approach inpatient diabetes education in a patient-based, individualized manner.

Sara Healy, MD
Endocrinology Fellow
Ohio State University

The study abstract was presented at ADA Scientific Sessions in June 2013 in Chicago, IL and was published in Diabetes Care in July 2013. Sara Healy is an Endocrinology Fellow at Ohio State University in Columbus, OH.

10:30am-10:45am
BREAK

10:45am-11:45am
Steps for Inpatient Management

A study, “The benefits of inpatient diabetes care: improving quality of care and the bottom line”, was completed within INTEGRIS Baptist Medical Center. This discussion will demonstrate how systems are implemented to better identify patients and to focus on quality improvements. Results of the study were: Hospital-wide training, earlier identification and implementation of inpatient protocols had positive results on both quality of care and the hospital’s bottom-line.

OBJECTIVES:
1. Discuss early implementation of inpatient hyperglycemia management protocol.
2. Discuss hospital wide and ongoing education.
3. Discuss implementation of hyperglycemia management protocol on impact of quality of care.

ATTENDEES WILL LEARN:
- To identify key roles for successful implementation of systems/protocols.
- Processes to detect diabetes earlier in the hospitalization.
- The impact of an evidence based hyperglycemia management protocol on patient satisfaction.

Tamara R Meier, APRN-CNS, MS, CCNS
Clinical Nurse Specialist Glucose Management Services
INTEGRIS Baptist Medical Center

INTEGRIS Baptist employs several advanced practice nurses in many different specialties. APRNs are licensed individual practitioners who practice independently yet collaboratively with physicians, nurses and other members of the health care team. APRNs medically manage and treat specific patient populations; they diagnose, order tests, perform procedures and write prescriptions. Several APRNs work to employ research and evidence based practice into daily care. Most importantly, they serve as an expert resource for physicians and nursing staff. APRNs impact the lives of patients in pediatrics, transplant, neonatal care, diabetes, cardiovascular services, palliative care, oncology, surgical services and nursing quality. Tamara Meier is the diabetes nurse specialist for Glucose Management Services. Meier is an advanced practice nurse with prescriptive authority certified in acute and critical care. In her previous position at Evident Health Services she worked extensively with patients in hyperglycemia and diabetes management. Meier leads the hyperglycemia care team and inpatient hyperglycemia and diabetes initiatives, including Joint Commission certifications.

11:45am-12:45pm
LUNCH
12:45pm-1:45pm
MOTIVATIONAL INTERVIEWING BY OCHSNER HEALTH COACHES DRIVES RESULTS IN 4 KEY AREAS

When health coaches employ motivational interviewing during patient encounters, expect upticks in medication adherence, weight loss, HbA1c levels and overall engagement, notes Alicia Vail, RN health coach for Ochsner Health System. Ochsner’s eight health coaches focus on patients with diabetes, hypertension and obesity who have come to their attention by way of physician referrals, health screenings and pre-chart reviews.

Ms. Vail describes how Ochsner Health System incorporates health coaches in its clinic structure and describes the benefits that result from the coaching intervention and will share how an evidence-based health coaching focus drives returns in a value-based payment delivery system.

Alicia Vail, RN
Health Coach
Ochsner Health System

1:45pm-2:45pm
A REMOTE DIABETES SELF-MANAGEMENT PROGRAM IMPROVES OUTCOMES IN ADULTS WITH DIABETES

Clinical measures are reported after a one-year remote diabetes self-management program. The multi-modal American Diabetes Association-based program was delivered by remote technology including interactive video and remote retinopathy assessments. The effective program resulted in improved access to diabetes specialists (RD and RN/CDE) and improved metabolic control and cardiovascular risk in adults with type 2 diabetes.

ATTENDEES WILL LEARN:
• Improving access to care and reducing health disparities.
• Evidence-based remote diabetes self-management education.
• Cost effective care delivery.
• Remote diabetes self-management is scalable.

Dr. Richard Davis, MD
Associate Professor, UNC Eye
Lead Research Navigator, NC TraCS Institute
Co-Director, UNC Center for Diabetes Translation Research to Reduce Health Disparities
UNC at Chapel Hill

The University of North Carolina at Chapel Hill has received a $3 million grant from the National Institute of Diabetes and Digestive and Kidney Diseases to establish the UNC Center for Diabetes Translational Research to reduce health disparities. Its mission is to reduce diabetes-related disparities among poor and underserved populations by providing resources and support to foster translational research in North Carolina and beyond. The center’s research will examine and compare different techniques for bringing effective preventive and therapeutic interventions into practice. Currently, 1 in nine adults in the U.S. has Type 2 diabetes. If trends continue, projections suggest that on in three people may have the condition by 2050. Diabetes related annual costs are currently $174 billion and may increase to $336 billion by 2034. Poor, minority and rural populations with limited access to health care suffer disproportionately. Especially in North Carolina, African-American, Hispanic and Native American populations have a higher rate of diabetes and related complications.

Dr. Davis with expertise in telemedicine and Telehealth has tools to support community translational research, which will lead to efforts to utilize technologies to improve health outcomes. The UNC CDTR is an example of how proposed new centers can leverage existing NC TraCS resources to enhance their proposals. Going forward the center will continue to rely on NC TraCS to help to quickly translate research findings into better diabetes prevention strategies and treatments. The goal is to improve health outcomes with regard to diabetes, not just in North Carolina, but nationally.

2:45pm-3:00pm
BREAK
3:00pm-4:00pm
TELEHEALTH – HYBRID HEALTH CARE FOR IMPROVED OUTCOMES

Diabetes Telehealth research to date has provided minimal description of its clinical protocols, including strategies used to foster behavior change and procedures to deliver diabetes self-management education and medical care. Also, there has been a focus on time-limited research interventions but little on working clinical programs. We describe here an effective diabetes Telehealth program (House-Calls) that serves an urban Medicaid population living with poorly-controlled type 2 diabetes. We also discuss barriers to the future scalability and long-term sustainability of such programs that our healthcare system will need to overcome if we are to provide population-level Telehealth solutions for the growing epidemic of T2DM. The rapid growth of Telehealth technologies has led to many misconceptions. New York City Health & Hospitals has pioneered a personalized approach that combines data transfer with expert individualized communications that allow patients to renew their belief that improvement is possible. The House Calls program seeks to move patients from a state of avoidance to embracing a problem solving approach by partnering with Diabetes educators. We model positive approaches to the challenges of DSM and move patients gradually into successful self-management.

OBJECTIVES OF PRESENTATION HIGHLIGHTS:
- Identification of a patient’s belief in the possibility of change.
- Acknowledge that change will occur over time.
- Acknowledge that without the patient’s agreement and participation in the plan of care, change will not occur.
- Identify the use of metaphors in DSME to convert abstract concepts into Tangible examples in activities of daily living.
- Identify barriers in referral channels and methods to overcome referral obstacles.

ATTENDEES WILL LEARN HOW TO:
- Use metaphors in DSME to convert abstract concepts into Tangible examples in activities of daily living.
- Elicit from a patient their main motivators and priorities in their daily life and translate those into motivators for successful DSM.
- Create referral mechanisms to support coordination of Care through Telehealth.

Susan Lehrer RN, BSN, CDE
Associate Director of Care Management
New York City Health Hospitals Corporation

Susan is a nurse and Certified Diabetes Educator and together with the administration of Health & Homecare, she designed and implemented the HHC Telehealth program called “House Calls” that provides care to poorly controlled individuals with diabetes and heart failure.

4:00pm-5:00pm
CURRENT AND EMERGING TECHNOLOGIES IN DIABETES CARE

The diabetes epidemic in the United States continues to grow in magnitude. Nearly 26 million Americans have diabetes, and another 79 million have pre-diabetes. If current trends continue, one in three Americans will face a life with diabetes by 2050. People with diabetes face acute and long-term complications in addition to the daily burden of managing the disease. In just 5 years, the financial cost of diagnosed diabetes and its complications increased by 41%, from $174 billion in 2007 to $245 billion in 2012. One in three Medicare dollars is spent on diabetes.

ATTENDEES WILL LEARN:
- Life Style and Fitness Apps
- Diabetes and Glucose Monitoring
- 2011 review revealed over 200 diabetes related apps
- New Insulins
- Future Insulins
- Artificial Pancreas Project

Anastasia Albanese-O’Neil, MSN, RN, CDE
University of Florida

Anastasia Albanese-O’Neil, MSN, RN, CDE, serves as a consultant at the University of Florida Diabetes Center and is pursuing doctoral studies that focus on the use of mobile health technology in diabetes care and management. She also serves as a diabetes nurse educator in the UF Health pediatric diabetes clinic. Before returning to graduate school in 2010, Anastasia was the administrative director for the Network for Pancreatic Organ Donors with Diabetes (nPOD) Project at UF, funded by the Juvenile Diabetes Research Foundation (JDRF). Anastasia has past experience as the highest-ranking marketing executive for Southwest Airlines in southern California, as a public relations manager in international logistics, and as a column editor at the Los Angeles Times. She currently serves on the Board of Directors at the Juvenile Diabetes Research Foundation, North Florida Chapter, and is a member of the American Diabetes Association’s National Advocacy Committee, Safe at School Work Group, and Legislative Subcommittee. She has also been a member of the board of directors at leading business organizations, including the Los Angeles Economic Development Corporation, the Los Angeles Chamber of Commerce, and the Southern California Association of Governments. Anastasia plans to retire within minutes of the discovery of a cure for type 1 diabetes, but not a moment earlier.

5:00pm
END OF CONFERENCE - DAY TWO
LISTEN TO WHAT ATTENDEES HAD TO SAY ABOUT THEIR EXPERIENCE

Linda Mino  
Frederick Memorial Health System, Maryland  
"Overall this was a wonderful conference, the speakers were top notch, well worth the conference fee"

Lourdes Braadt  
Bon Secours Health System, New York  
"I enjoyed every bit of this conference"

Jodi Balch  
Ochsner Medical Center, Louisiana  
"I thoroughly enjoyed the conference"

Alicia Fletcher  
MCH Diabetes Center, Texas  
"Loved the topics and speakers"

Peggy Bolton  
Ochsner Medical Center, Louisiana  
"We definitely enjoyed the conference"

Joanne Archer  
Wheaton Franciscan Hospital, Wisconsin  
"Caliber of the speakers were terrific"

Debra Shaw  
Mercy Medical Center, Ohio  
"Overall it was a very informative meeting"

Robin Stevens  
Health Alliance, New York  
"The meeting was great!"

Tracey Stadler  
Fischer Titus Medical Center, Ohio  
"Had a wonderful time, information was great"

Accredited status does not imply endorsement by WISNA, Current Advantage, or ANCC of any, or ANCC of any commercial products or services.

Ms. Jane Jeffrie Seley has disclosed that she is a consultant for Bayer Diabetes while all other speakers have nothing to disclose.

Thank you to all of our Media Partners that have helped to market our event!

This meeting will be held at Hilton Tampa Airport Westshore  
2225 N Lois Ave, Tampa, Florida  
Our discounted room rate is $105 per night. You must call the hotel when registering for your room and identify yourself as being with Current Advantage.  
Hilton Tampa Airport Westshore is 2 miles from Tampa International Airport.  
There will be a free shuttle service offered to guests.

FOR MORE INFORMATION OR TO REGISTER CALL GIA BOSCH AT 414-255-9525  
gbosch@currentadvantage.com