Welcome to the 2009 AADE Annual Meeting!

Seton Health Presents:

Defy Diabetes! A unique CDE partnership with faith community nurses and primary care nurse champions to reduce diabetes risk factors and improve diabetes management within the chronic care model.

Presented by:
Nancy Brennan-Jordan, FNP, CDE
Diane Deeley, RN, CDE
Debra Frenn, MSN, FACHE

Objectives

1. Describe the role of the faith community nurses and how they partner within the chronic care model.

2. Describe the role of the Defy Diabetes nurse champions and how they partner with the diabetes educator.

3. Discuss quarterly results of a dynamic chart review process and it's impact on diabetes management in primary care.

Introduction / History

Seton Health is an integrated Catholic health care system anchored by St. Mary's Hospital in Troy, NY and provides services to residents of Rensselaer, Southern Saratoga & Northern Albany counties.

- 155 years
- Over 20 locations
- Primary Care, OB/GYN, Specialty Services, Long-Term Care, Imaging, Home Care
- A member of Ascension Health
- In December 2007 Seton Health received a two-year grant from the New York State Health Foundation (NYSHF).

Defy Diabetes!
Goals & Objectives

Comprehensive Program for Diabetes Detection & Management which will:

- Reach 1000 people through Seton's Faith Community Nurse Program
- Engage 25 primary care practice teams empowering nurse champions
- Develop web based diabetes data registry to track progress and outcomes

Expected Outcomes

- Reduction in diabetes risk factors in those with diabetes and pre-diabetes
- Strengthen ADA Guidelines in primary care practices

Logic Model for *Defy Diabetes!*

SITUATION

Diabetes Epidemic in the Capital Region

PRIORITIES

Mission:

Seton Health's Mission
...we commit ourselves to serving all persons with special attention to those who are poor and vulnerable. Our Catholic health ministry is dedicated to spiritually-centered, holistic care, which sustains and improves the health of individuals and communities.

Seton Health's Call to Action
- Health Care that Works
- Health Care that is Safe
- Health Care that leaves no one behind

Mission of NYS Health Foundation
- Increasing access to high-quality health care
- Strengthening public and community health by educating New Yorkers about expanding health insurance coverage for those who can not afford coverage or for whom coverage is inadequate.
- Empowering communities to address health care issues

INPUTS

Funding from the NYSHF

Seton Health:
- Faith Community Parish Nurse Program
- Seton Health's ADA accredited Out Patient Diabetes Ed Program
- Larger primary care network; physician champion, nurse champions
- IT Department

Research and Best Practices; ADA Guidleines

Partners:
- Hispanic Outreach Services
- Cornell Cooperative Extension
- Sage Colleges
- SUNY School of Social Welfare
- Albany Med
- St Peters Family Health Center
- Community Gardens
- ADA local chapter

Equipment

Ascension Health Network

Space

Faith Communities (MOU's signed)

Time

OUTPUTS (ACTIVITES)

- Health Fairs
- Pulpit talks
- Healthy Living Class Curriculum development
- Healthy Living Classes held in English and Spanish
- Training program FCPN's and 2 HOS community health promoters
- Educational In-services to primary care network
- Dynamic NCQA Chart Reviews
- Training Modules for Nurse Champions
- Develop Diabetes Data Registry
- Implement Harbor software for out pt tracking
- Develop Share Point
- Focus Groups

REACH

- Reach 1,000 people through Seton's Faith Community Parish Nurse Program
- Primary Care Network
- Pt with diabetes and at risk for diabetes

OUTCOMES

Short Term

Collect and Monitor the following measurable outcomes:

Faith Community Participants:
- HES
- Self Care
- Focus group results
- Wt
- Height
- BP
- Waist circumference
- If DM, HgA1c, BP, LDL

Primary Care Network

Chart Reviews (NCQA Guidelines)
- A1C
- Blood Pressure
- LDL
- Foot Exam
- Eye Exam
- Smoking Status
- Nephropathy Assessment
- Referrals to Diabetes Education

Medium:

A decrease is risk factors for persons living with Diabetes and at risk for diabetes

Improved diabetes management of personls living with diabetes in the Seton Health network

Increased compliance with the ADA Guidelines in primary Care

NCQA Recognition Awards for Seton Health's primary care providers

The primary care network and Ascension Health can access updated diabetes information through Share Point

Long Term:
- Improve public health
- Replicate the defy diabetes nurse champion/FCPN model in primary care practices throughout NYS and Ascension Health
- Improve the primary care system
- Increase Community resources to reinforce the adoption of prevention and management activities
- Reduce medical costs

The Situation: The New York Diabetes Epidemic

- More than 1.7 million New Yorkers have diabetes
  - 1.1 million have been diagnosed with diabetes. [1]
  - 733,000 have diabetes but don't know it. [1]
- That's more people than the total population for Manhattan or all of Western New York.
- An estimated 3.7 million New York adults are estimated to have pre-diabetes. [2]

SETON HEALTH
Defy Diabetes

Source [1]: New York State Department of Health (calculated from BRFSS 2007)
Source [2]: New York State Department of Health

Disparities in Diabetes

- Diabetes disproportionately affects Black, Latino, and low-income New Yorkers. [1]
- Diabetes is the third leading cause of death among Blacks and the fifth among Hispanics. [1]
- Half of all Asians in New York City have either diabetes or pre-diabetes. [2]

Source [1]: Vital Statistics of New York State, 2005. <http://www.health.state.ny.us/nysdoh/vital_statistics/2005/>
Source [2]: The New York City Health and Nutrition Examination Survey. New York City Department of Health and Mental Hygiene, 2004

Disparities Example

- White patients were significantly more likely than Black patients to achieve control of three critical health measure for diabetes patients: hemoglobin A1c, LDL, cholesterol, and blood pressure. [1]

	White Patient	Black Patient
Hemoglobin A1c <7%	47%	39%
LDL Cholesterol <100 mg/dl	57%	45%
Blood Pressure < 130/80 mmHg	30%	24%

Economics of Diabetes

- Estimated total cost of diabetes in New York State in 2006 was more than $12 billion. [1]
  - $8.676 billion: excess medical expenses
  - $4.188 billion: value lost in productivity
- Health care cost for New Yorkers living with diabetes are more than five times as much as New Yorkers without diabetes—$13,000 vs. $2,500. [2]

Source [1]: Economic Costs of Diabetes in the U.S. in 2007, American Diabetes Association. Diabetes Care, 2008 Mar;31(3):596-615.

Source [2]: Center for Disease Control Website, DDT

Priorities / Mission

The NYSHF is a private foundation formed in 2006 with a three-part mission:

- increasing access to high-quality health care
- strengthening public and community health by educating New Yorkers about expanding health insurance coverage for those who cannot afford coverage or for whom coverage is inadequate.
- Empowering communities to address health care issues

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...we commit ourselves to serving all persons with special attention to those who are poor and vulnerable. Our Catholic health ministry is dedicated to spiritually-centered, holistic care, which sustains and improves the health of individuals and communities.

- **Health Care that works**
- **Health Care that is safe**
- **Health Care that leaves no one behind**

Inputs/Partners

- The New York State Health Foundation (NYSHealth) has committed $35 million over five years toward a statewide campaign to reverse the epidemic of diabetes in New York.
- Faith Community Nurse Program
- ADA Accredited Out Pt Diabetes Education Program
- Hispanic Outreach Services
- Sage College of Nursing
- SUNY School of Social Welfare
- Cornell Cooperative Extension

What is a Faith Community Nurse?

The Seton Health Faith Community Nurse Program is an **interfaith** Ministry designed to promote health and wellness within local faith communities.

A faith community nurse is a registered nurse who serves the faith community as a health educator, personal health counselor, advocate, referral agent and volunteer coordinator.

SETON HEALTH
Defy Diabetes

Outputs: Activities

#1 Community Intervention

- Healthy Living Classes (English and Spanish)
- Pulpit Talks
- Health Fairs

PARISH NURSE MINISTRIES

Outputs: Activities

#2 Primary Care Interventions

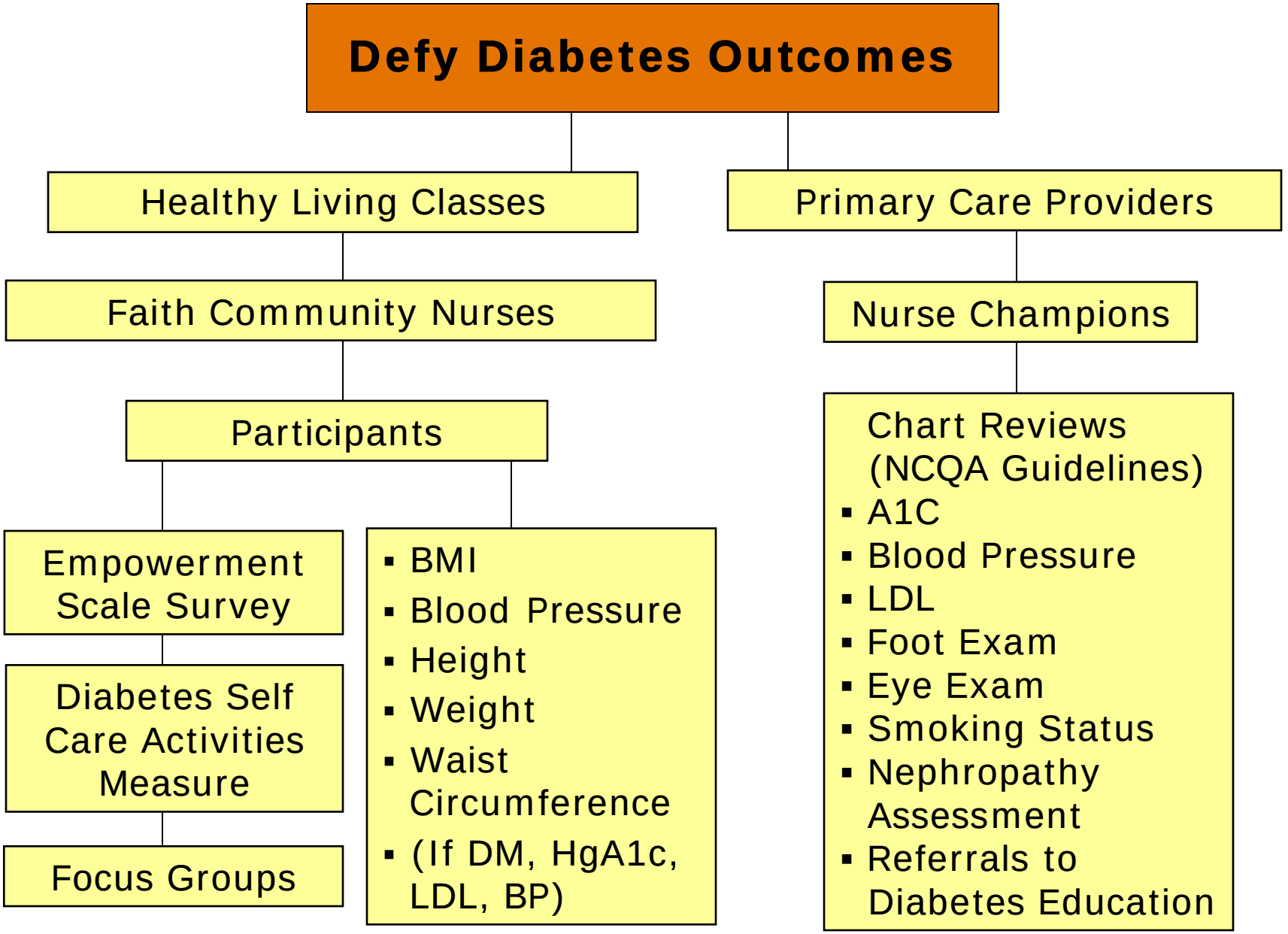
- Defy Diabetes chart reviews; tool is reflective of NCQA Recognition criteria
- **The nurse champion serves as the "change agent"**
- Provide feedback, results of chart reviews and education to staff for continued improvements of diabetes management

What Is A Defy Diabetes Nurse Champion?

A Defy Diabetes Nurse Champion Is:

- Passionate about diabetes
- Someone who strives for excellence in the management of their patients living with diabetes
- Someone who develops and implements strategies to improve outcomes


you can
YES DEFY
DIABETES!
SETON
HEALTH


Defy Diabetes Outcomes
Healthy Living Classes
Faith Community Nurses
Participants
Empowerment Scale Survey
Diabetes Self Care Activities Measure
Focus Groups
BMI
Blood Pressure
Height
Weight
Waist Circumference
(If DM, HgA1c, LDL, BP)
Primary Care Providers
Nurse Champions
Chart Reviews (NCQA Guidelines)
A1C
Blood Pressure
LDL
Foot Exam
Eye Exam
Smoking Status
Nephropathy Assessment
Referrals to Diabetes Education

Defy Diabetes – Primary Care Providers Chart Review Results

1st Quarter Review (July-October 2008)

- 7 Sites
- 28 Providers
- 275 Charts Reviewed

2nd Quarter Review (October – December 2008)

- 7 Sites
- 32 Providers
- 355 Charts Reviewed

3rd Quarter Review (January – March 2009)

- 7 Sites
- 33 Providers
- 322 Charts Reviewed

Defy Diabetes – NCQA Recognition Program

Scored Measures	Threshold % Pts/Sample	Weight
HbA1c Control ≤ 7.0 %	**40 %**	10.0
HbA1c Control > 9.0 %	**≤ 15 %**	15.0
BP Control >140/90 mm Hg*	**≤ 35 %**	15.0
BP Control < 130/80 mm Hg	**25 %**	10.0
LDL Control > 130 mg/dl	**≤ 37 %**	10.0
LDL Control <100 mg/dl*	**36 %**	10.0
Eye Examination	**60 %**	10.0
Foot Examination	**80 %**	5.0
Nephropathy Assessment	**80 %**	5.0
Smoking Status & Cessation Advice or Rx	**80 %**	10.0
	Total Points	**100.0**
	Points to Achieve Recognition	**75.0**

*Denotes poor control

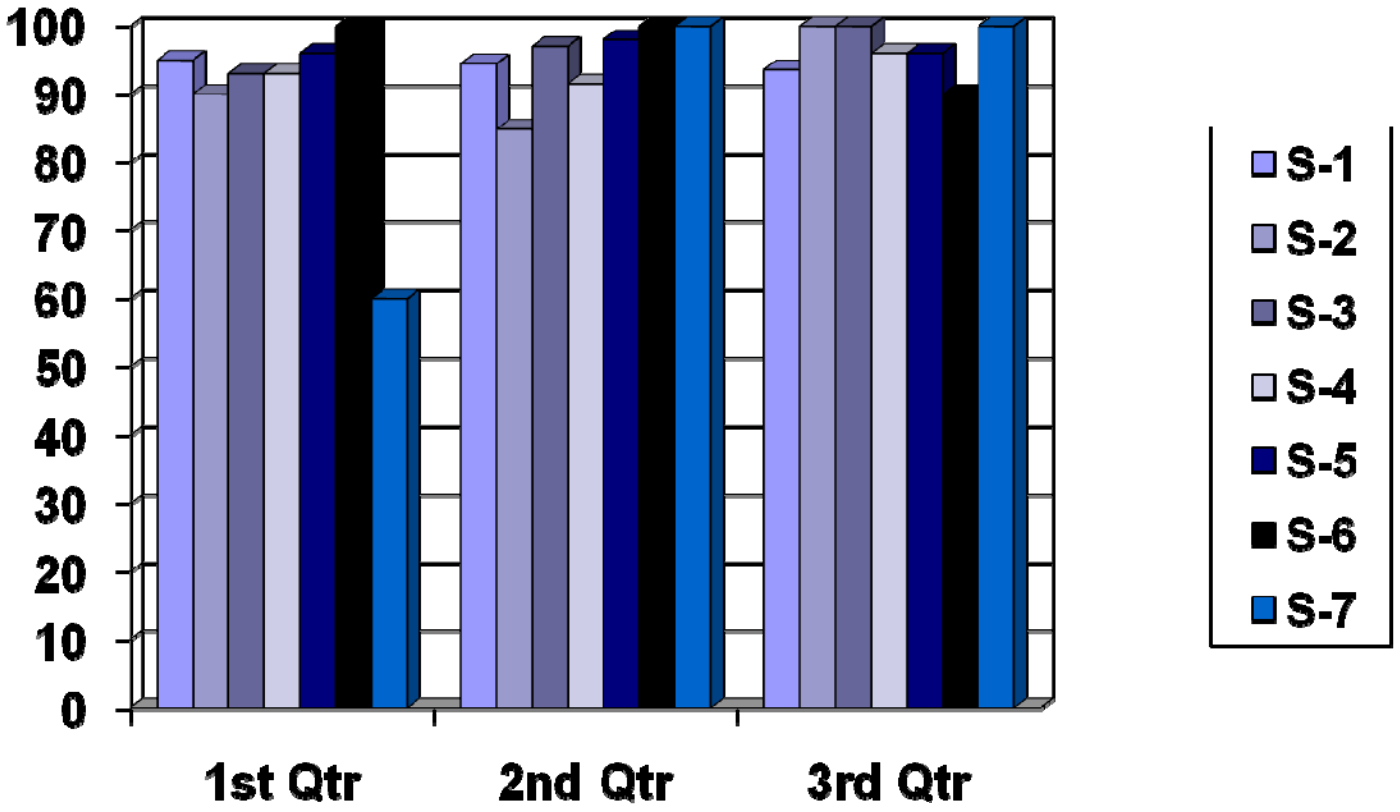
Chart Assessment Tool

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	DEFY DIABETES DATA COLLECTION TOOL		Enter 1 for Yes and 0 for No												
2	Provider/Location		CHARTS												
3	Status:		1	2	3	4	5	6	7	8	9	10	11	12	13
4	HbA1C done within 6 months														
5	HbA1C Control HbA1c < 7.0%														
6	HbA1C Control HbA12c > 9.0%														
7	Blood Pressure BP< 130/80														
8	BP > 140/90														
9	LDL done within 1 year														
10	Cholesterol Control LDL < 100														
11	Cholesterol Control LDL > 130														
12	Eye Exam														
13	Foot Exam														
14	Nephropathy Assessment														
15	Smoking Status and Cessation Advice or Treatment														
16															

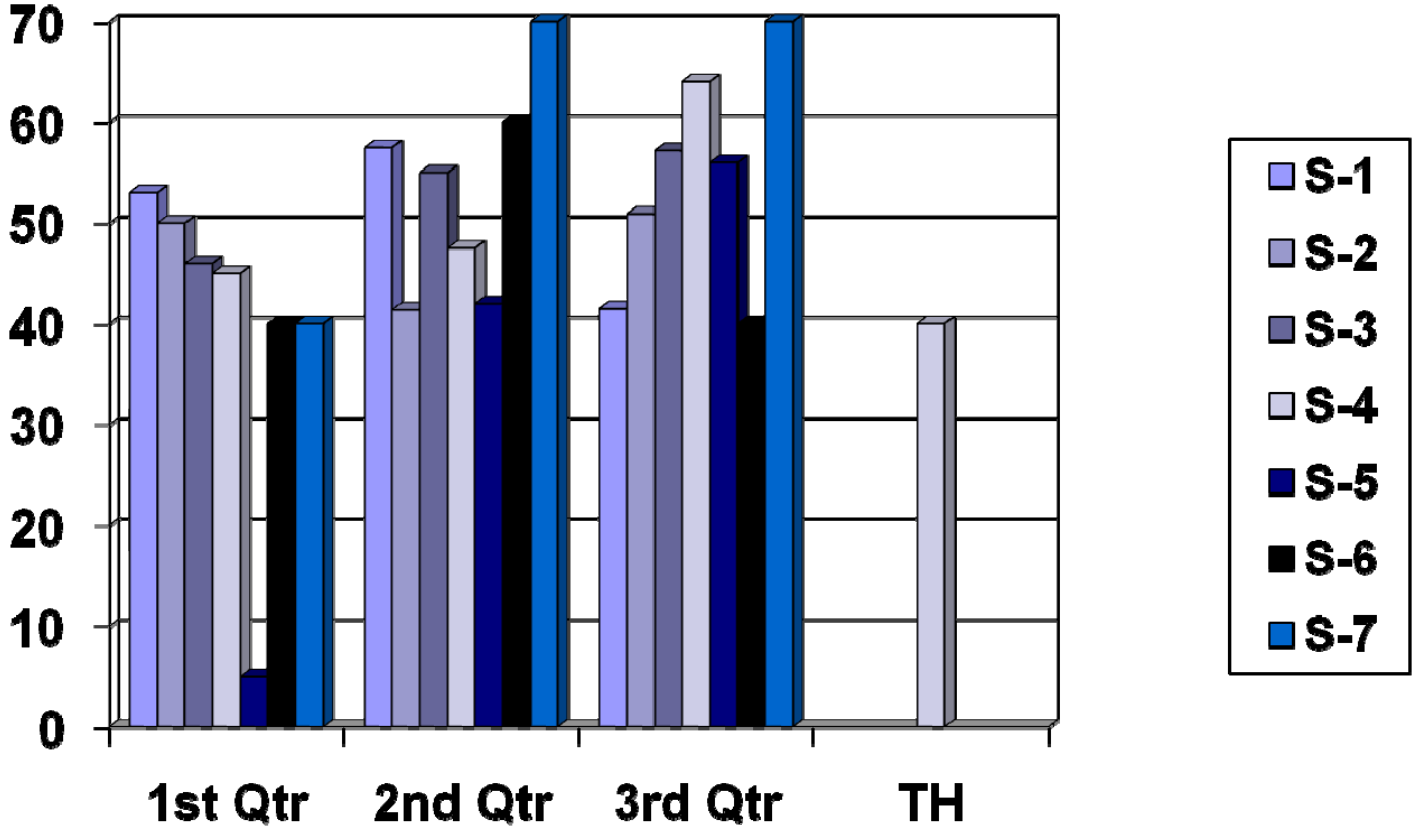
Sample P12 Results

SETON HEALTH			
DEFY DIABETES			
P-12 Percent of Success	1st Q	2nd Q	3rd Q
HbA1C done within 6 months	90.0%	100%	100.0%
HbA1C Control HbA1c < 7.0%	30.0%	40%	80.0%
HbA1C Control HbA12c >9.0%	30.0%	10%	0.0%
Blood Pressure BP< 130/80	50.0%	70%	60.0%
BP > 140/90	30.0%	0%	40.0%
LDL done within 1 year	100.0%	100%	100.0%
Cholesterol Control LDL < 100	80.0%	70%	80.0%
Cholesterol Control LDL > 130	0.0%	10%	10.0%
Eye Exam	40.0%	40%	30.0%
Foot Exam	10.0%	10%	40.0%
Nephropathy Assessment	70.0%	50%	100.0%
Smoking Status and Cessation Advice or Treatment	90.0%	90%	90.0%

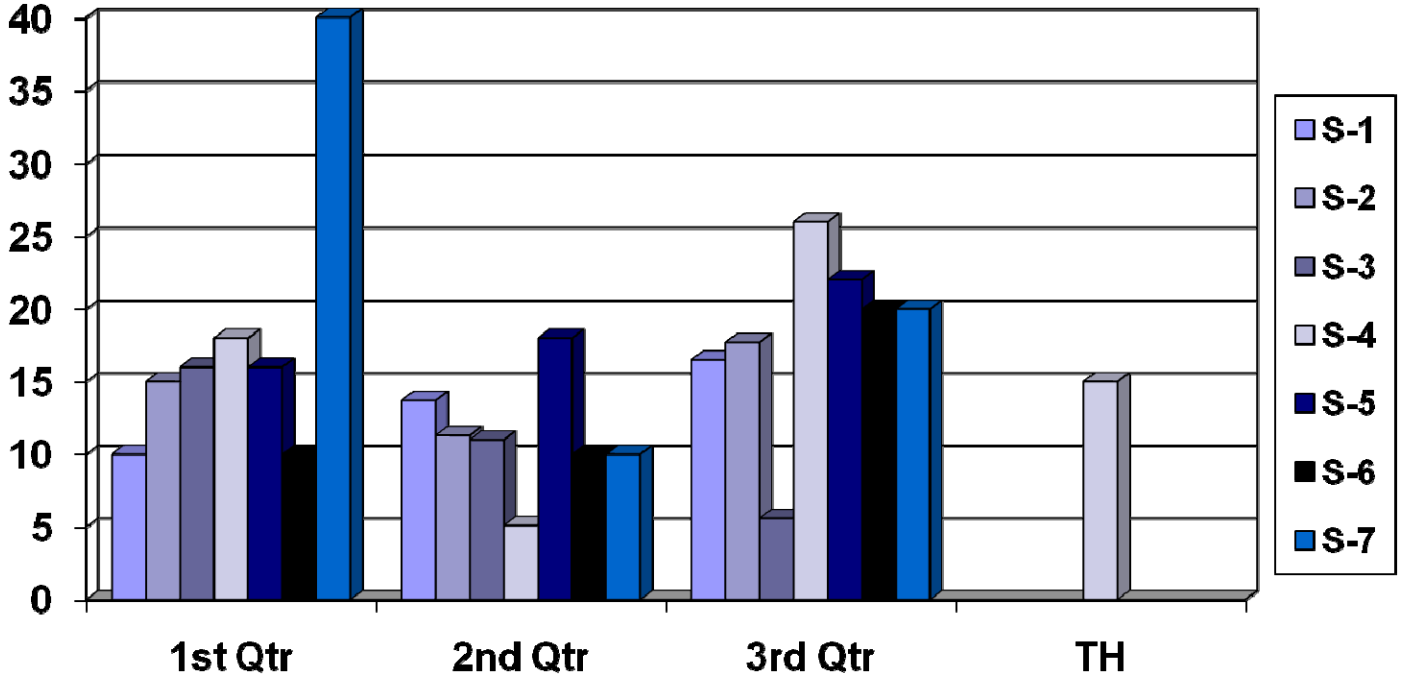
HbA1c Compliance q 6 Mos.



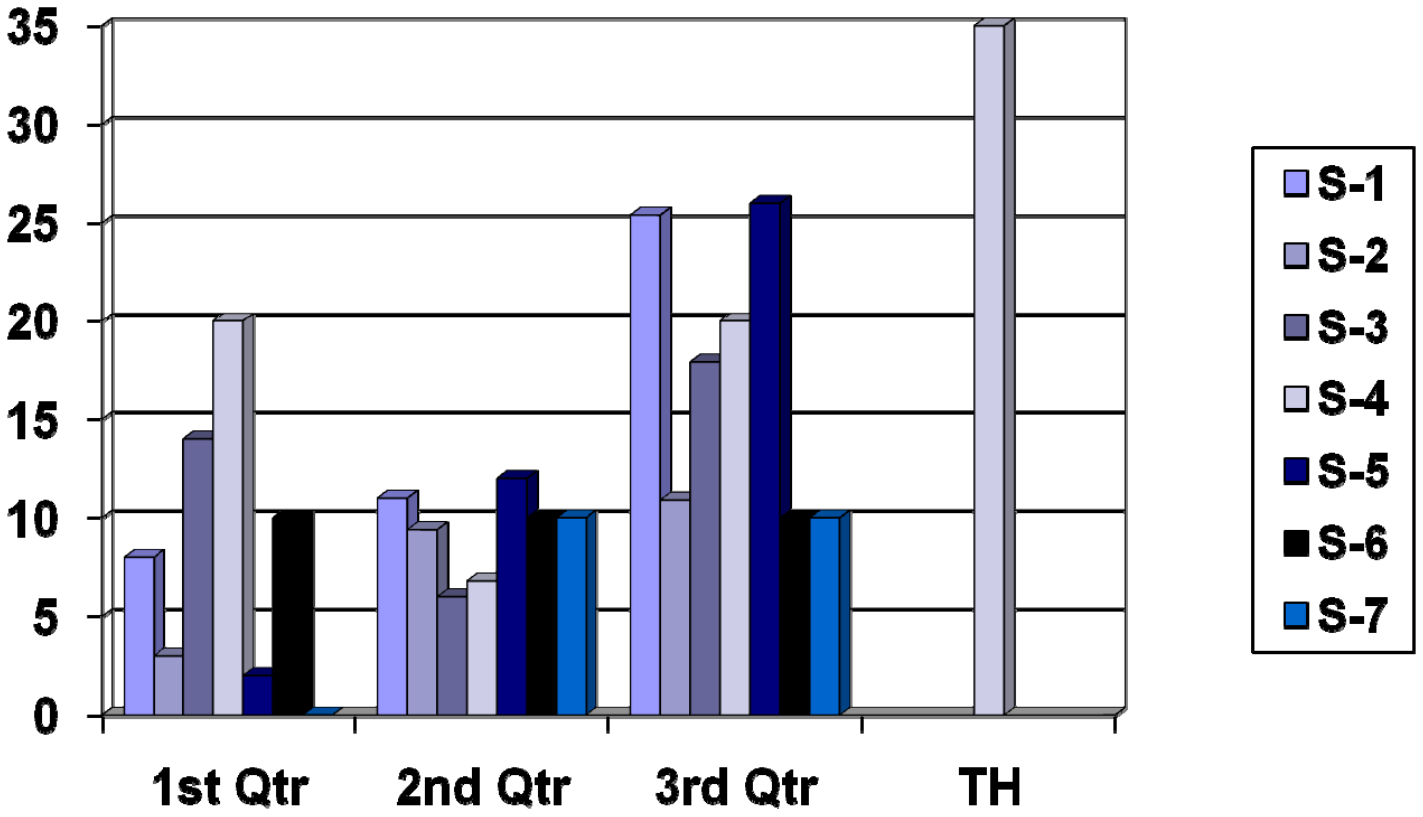
HbA1c Control < 7.0 %



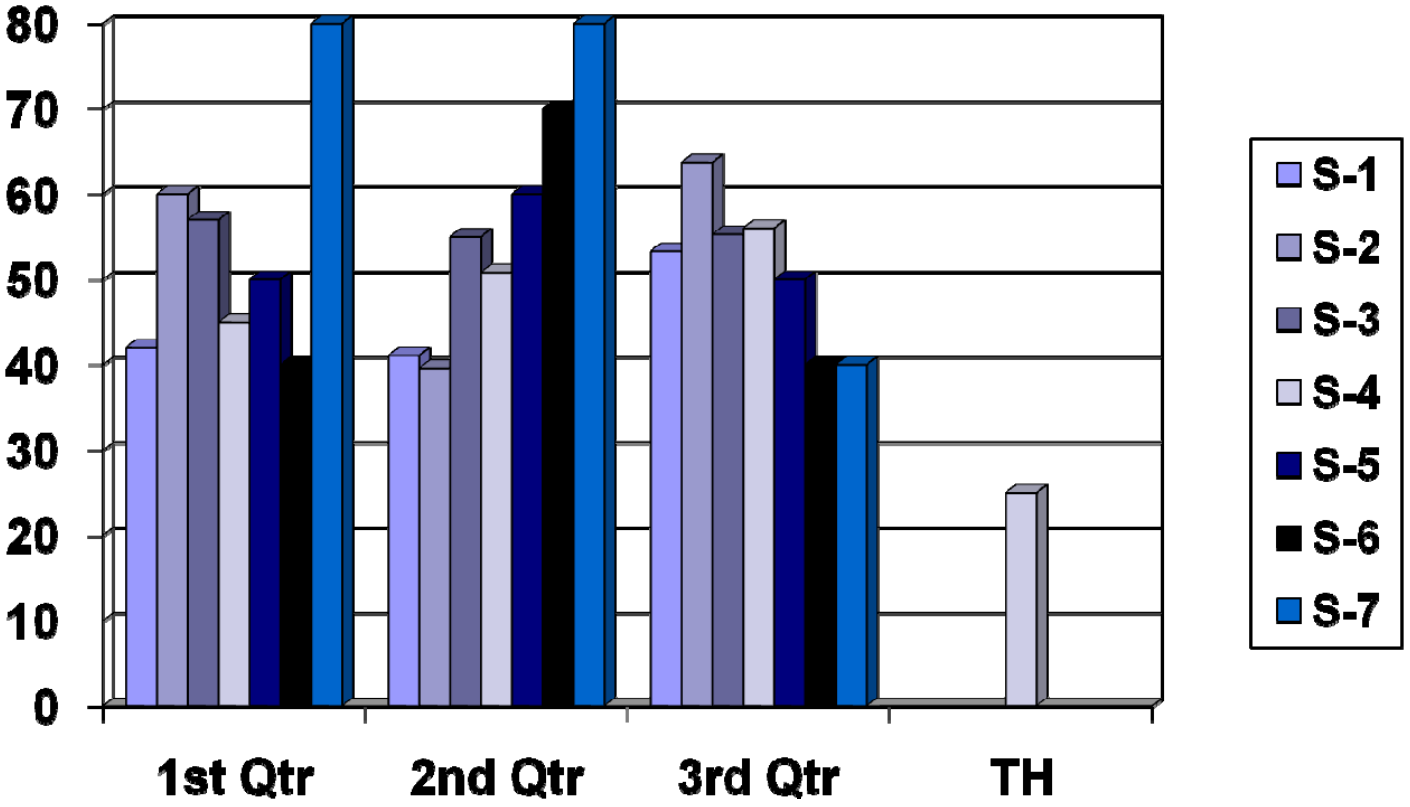
HbA1c Control > 9.0 %



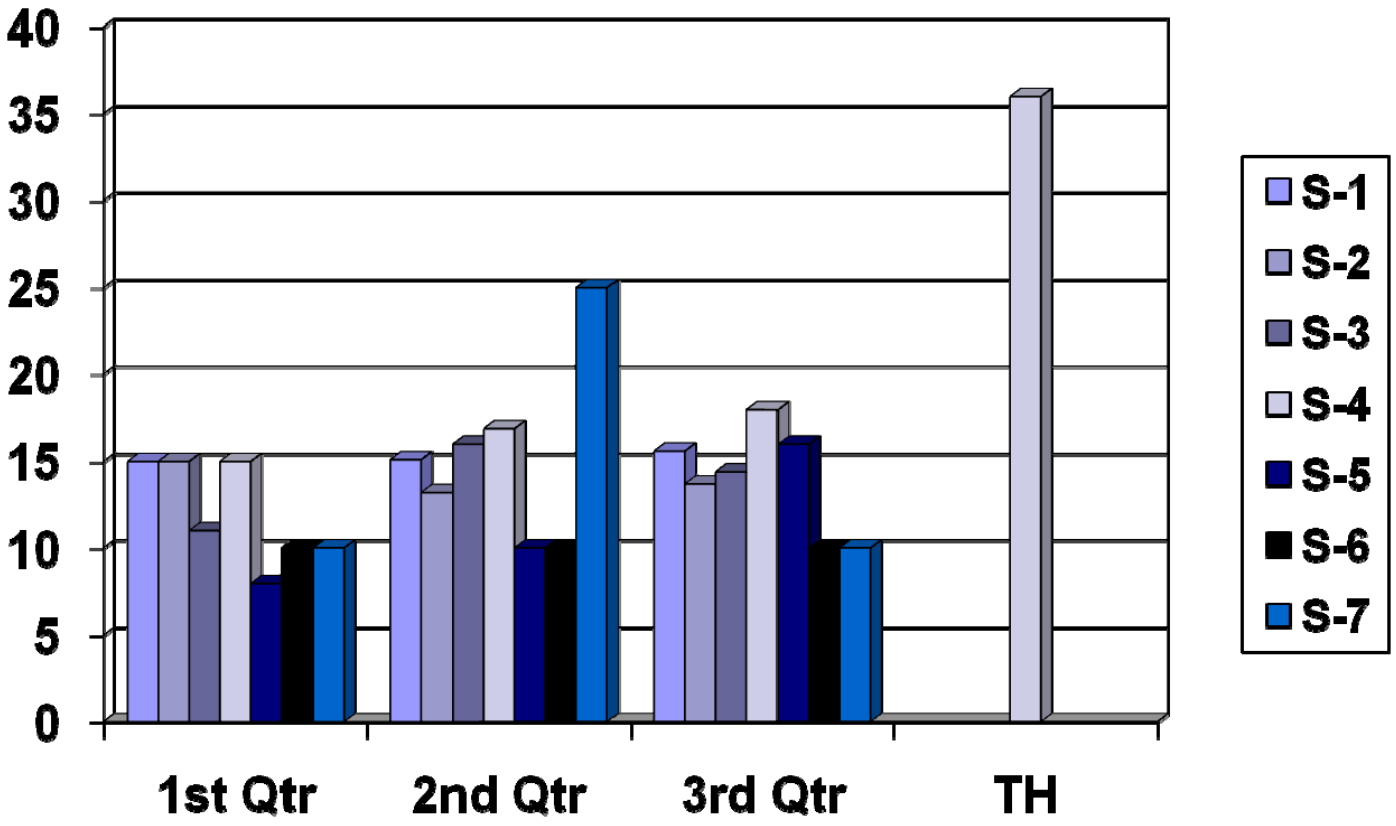
BP Control ≥ 140/90



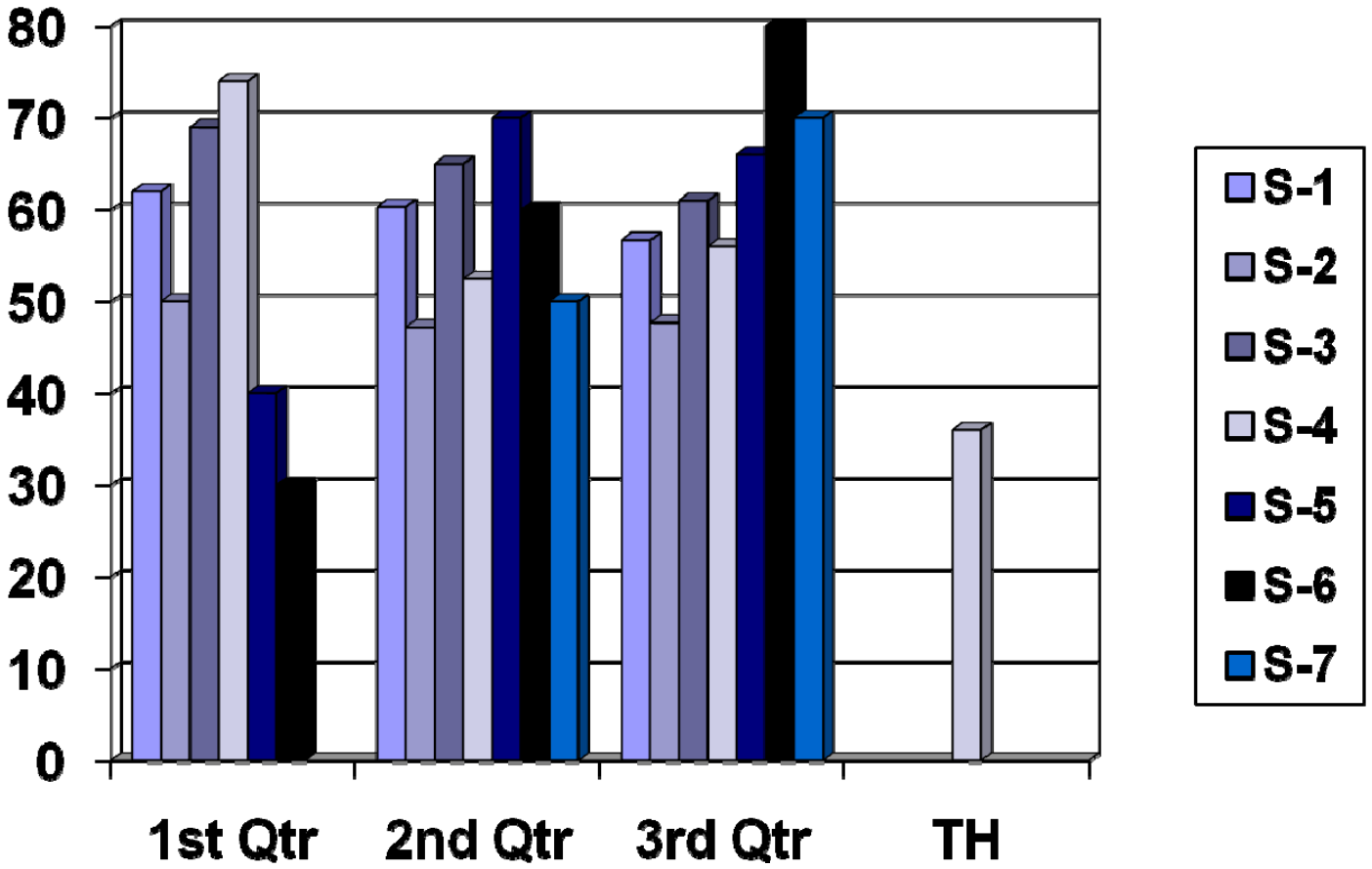
BP Control ≤ 130/80



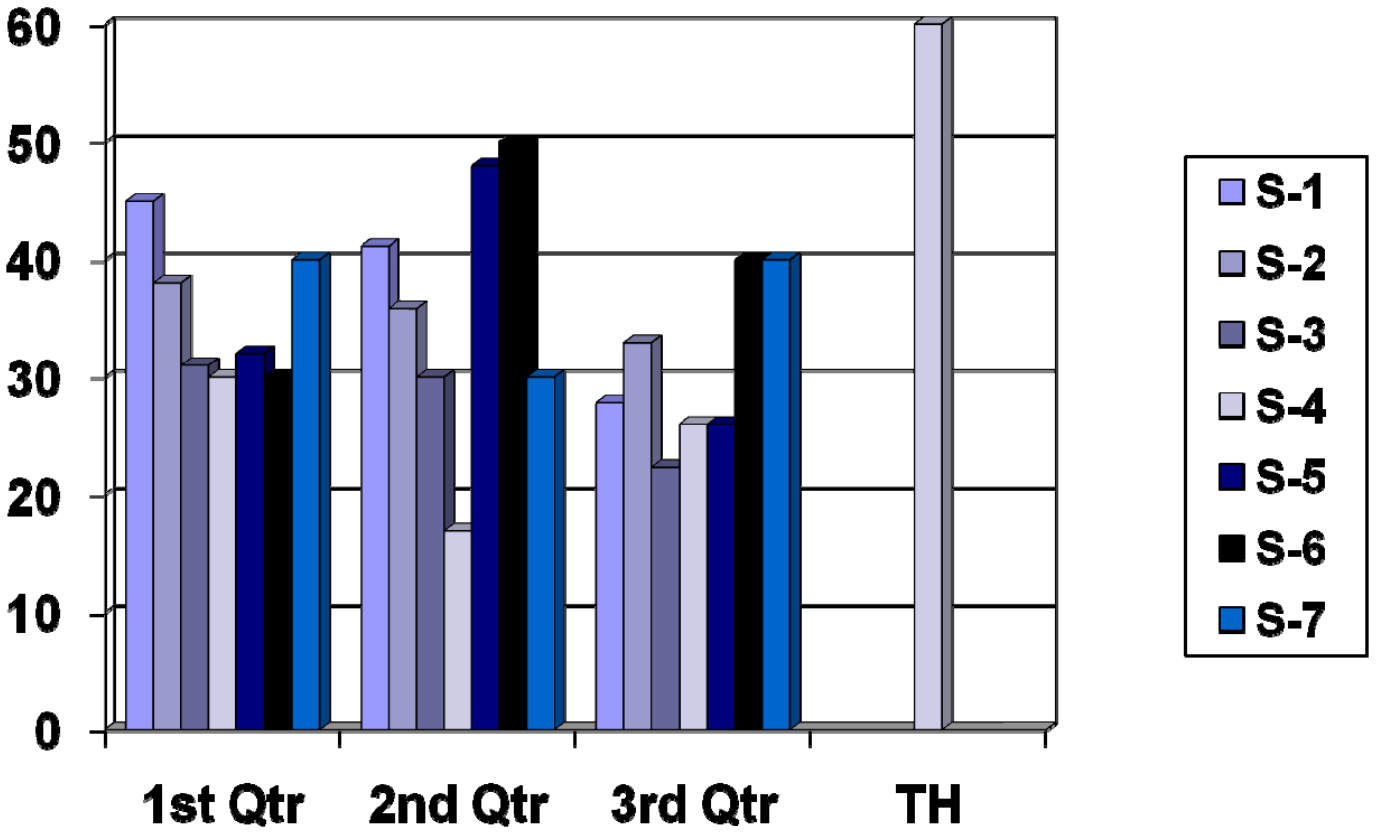
LDL Control > 130 mg/dl



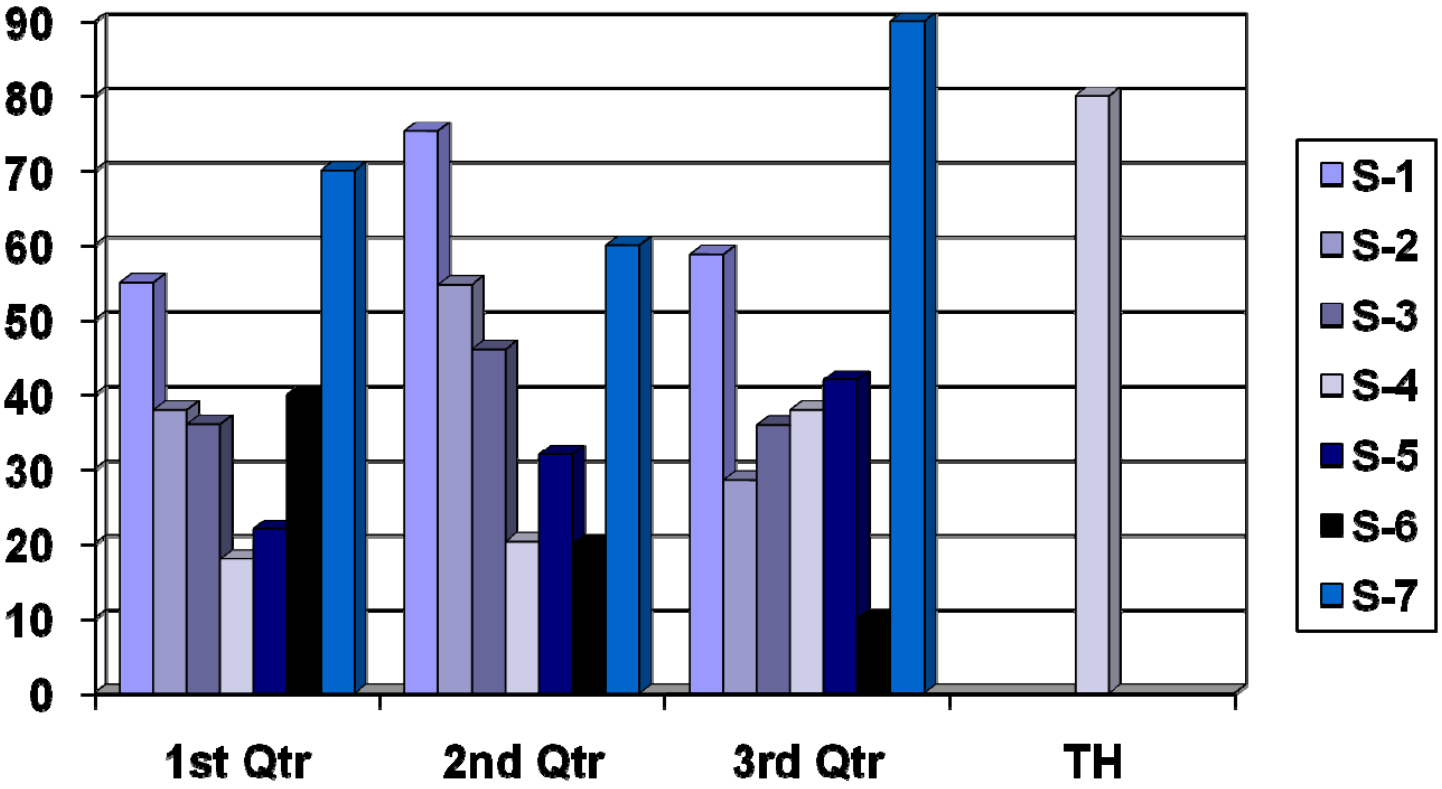
LDL Control < 100 mg/dl



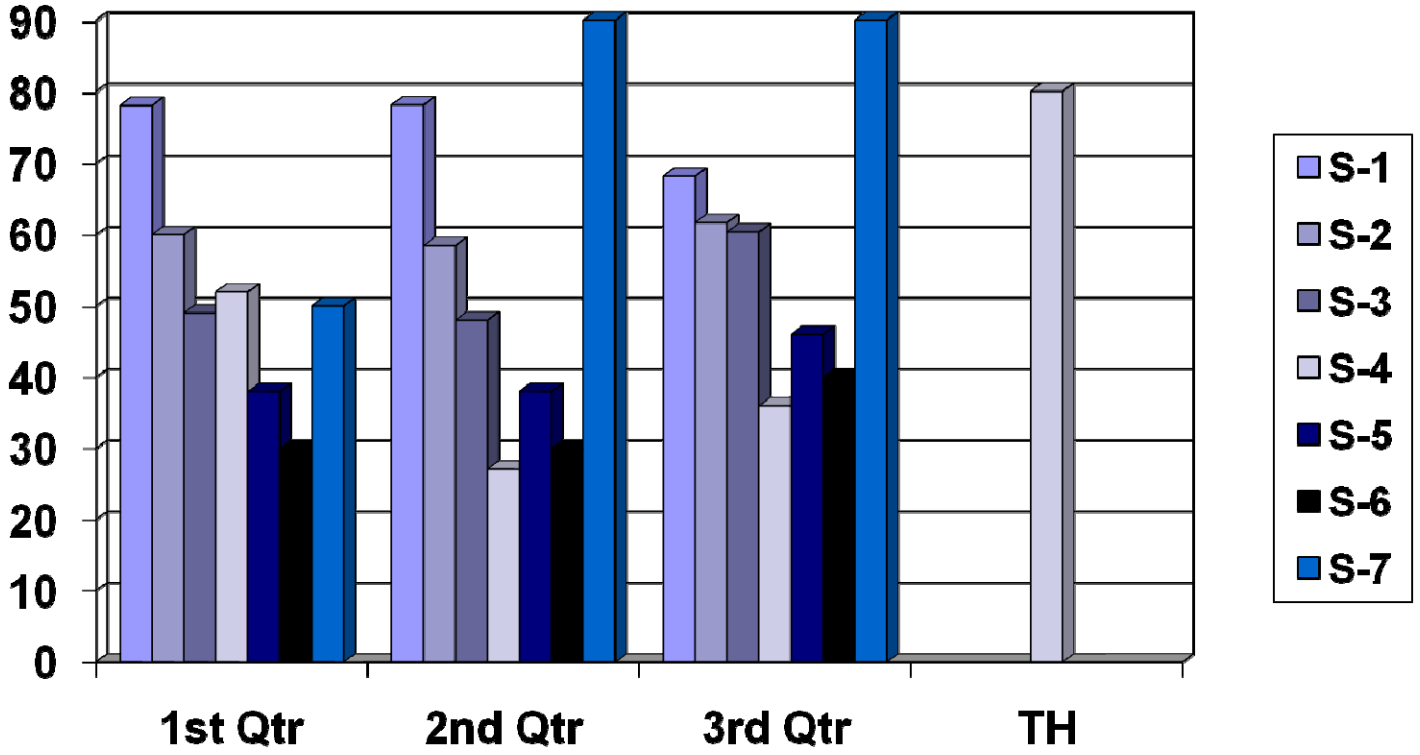
Eye Examination



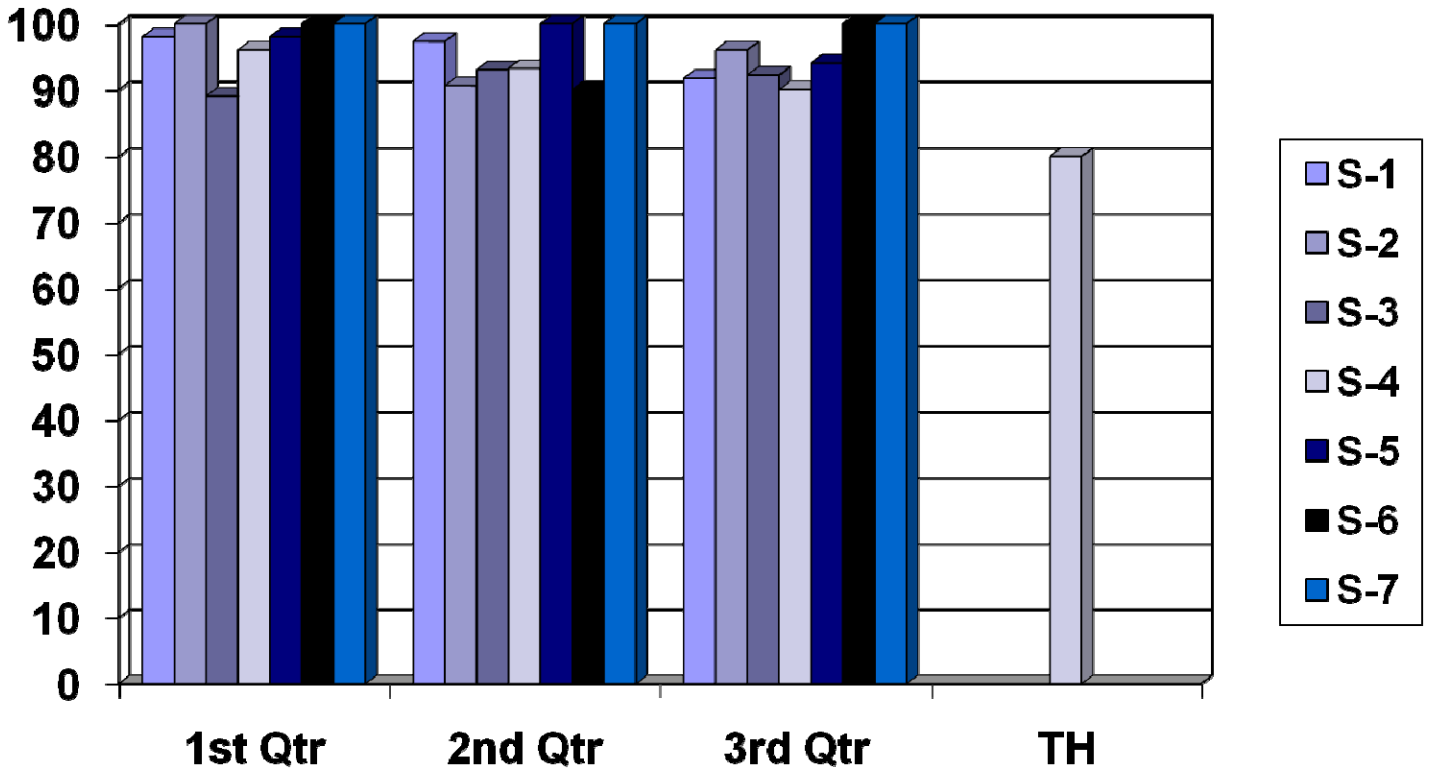
Foot Examination



Nephropathy Assessment



Smoking Status & Cessation Advice/Tx



Defy Diabetes Summary
1st, 2nd, 3rd Quarters

FIVE DPRP MEASURES MET

- HbA1c Control ≤ 7.0 %
- BP Control >140/90 mm Hg*
- BP Control < 130/80 mm Hg
- LDL Control > 130 mg/dl
- LDL Control <100 mg/dl

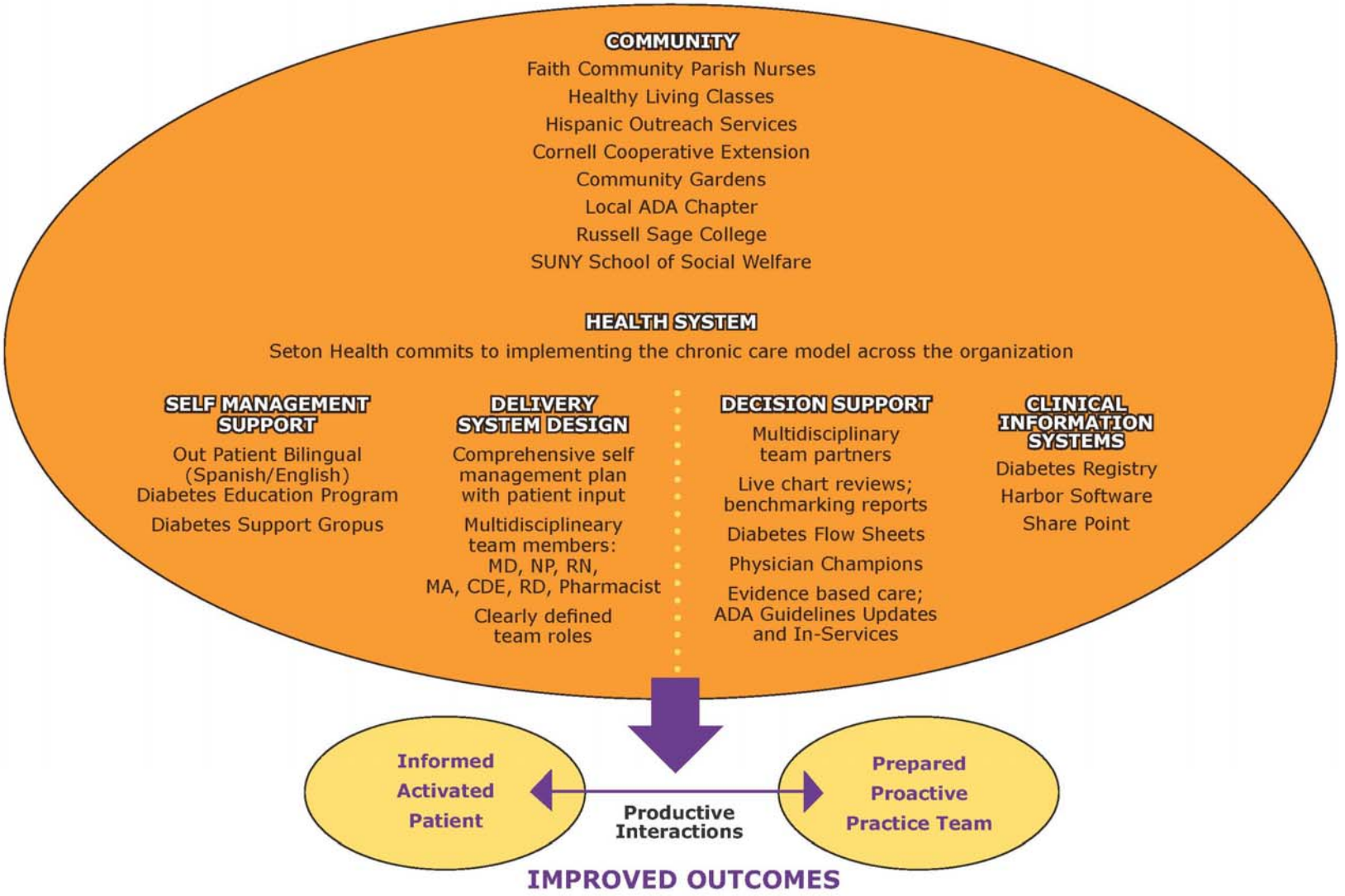
TWO DPRP MEASURES PARTIALLY MET

- Smoking Status & Cessation/Advice/Rx

FOUR DPRP MEASURES NOT MET

- HbA1c Control >9.0%
- Eye Examination
- Foot Examination
- Nephropathy Assessment

The "Setonized" Chronic Care Model



Innovative New Model for the Future

- An **INNOVATIVE** approach that has not been tried before; Faith Community Nurse Model.
- Replicable **NEW** model for Ascension Health Network and other hospitals with FCN Programs and primary care networks.

ASCENSION HEALTH

The CDE Take Home Messages

- #1 Consider partnering with Faith Community Nurses
- #2 Nurse Champions: "Agents for Change" in Primary Care
- #3 "Individualize" the Chronic Care Model for your health system

Any Questions? Thank You

Contact Information

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nbrennanjordan@setonhealth.org

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ddeeley@setonhealth.org

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