DPAC FORUM 2022

Food For Thought

AGENDA

Welcome Sally Joy Award	**Lauren Neely, MPH, CHES** Manager, MDHHS Diabetes and Kidney Unit
Trinity Health Diabetes Care & Nutrition Service and the Farm at Trinity Health	**Clisty S. Kinlin, MS, RDN, CDCES, DipACLM** Trinity Health Diabetes and Nutrition Education Coordinator
Fresh Food Pharmacy Pilot Program: Overview and Lessons Learned	**Amanda Feighner, MS, RDN** Community Nutrition and Health Programs Manager South Michigan Food Bank
Break	
The Intersection Between Chronic Illness, Mental Health, and Suicide	**Kristen Smith, Ph.D., LMSW** PRiSMM Program Coordinator MDHHS, Injury & Violence Prevention Section
Lunch and Learn November – Diabetes Awareness Month	
Advocacy Updates	ADA and DPP
Take It To Heart: SGLT2 Inhibitors and Cardiovascular Outcomes in Diabetes	**Corey Rowe, PharmD** Executive Fellow, Michigan Pharmacists Association
Structured Networking	All attendees
Wrap-up and Evaluation	

https://www.research.net/r/LCZKVMY

DIABETES PREVENTION AND CONTROL PROGRAM UPDATES

DIABETES IMPROVEMENT PLAN 2021-2025

State Leadership	Diabetes Prevention	Diabetes Management
Enhance network partnerships.	Reduce barriers to Diabetes Prevention Program (DPP) participant engagement and success.	Enhance medical coverage of Diabetes Self-Management Education and Support (DSMES).
Engage leaders.	Enhance policy and coverage for prediabetes and the DPP.	Increase utilization of technology.
Drive innovation and expand cross-program collaboration.	Build systems to support 'Screen, Test, Refer' for prediabetes.	Increase incentives for health care providers.
Provide support and educational opportunities for diabetes professionals.		Advance care for people living with diabetes.

SALLY JOY AWARD PRESENTATION

Jennifer Nicodemus

Director of Health Innovation,
MI Alliance of YMCAs

Trinity Health Diabetes Care & Nutrition service and the Farm at Trinity Health

Clisty Kinlin, MS, RDN, CDCES, DipACLM

Quality Coordinator

11/3/22

My story

- Registered Dietitian
- MS in human nutrition
- Certified Diabetes Care and Education Specialist for the past 17 years
- 2020 became board certified in Lifestyle Medicine
- Employed by Trinity Health for over 15 years
- Quality Coordinator for the past 7 years

Trinity Health

Trinity Health Diabetes Care & Nutrition

- We've been around for ~25 years
- Recent name change from St. Joseph Mercy Center for Diabetes
- Certified through MDHHS and ADCES
- Two Locations
  - Ypsilanti, MI – Washtenaw County
  - Howell, MI – Livingston County

Trinity Health

Services

- Type 1 Diabetes, Type 2 Diabetes, Gestational Diabetes
- Basic Diabetes Education
  - Individual
  - Group Classes
- Intensive MDI Therapy
- Insulin Pump Education
- Continuous Glucose Monitors
- Medical Nutrition Therapy for diabetes and non-diabetes diagnosis
- Lifestyle Medicine

What is Lifestyle Medicine

- Six pillars of Lifestyle Medicine
  - Stress management
  - Whole-food, plant-predominant eating pattern
  - Restorative sleep
  - Positive social connections
  - Physical activity
  - Avoidance of risky substances

Reach of Services

- Serve 315 providers
- 800 patients
- Average A1c reduction of 1.7%
- Implemented telehealth services within a month of the pandemic

“I would recommend this total program to anyone and everyone. Following the instructions for portion control and basic weight loss and exercise. I am feeling great!! I appreciate the instructors and their insight into everyday healthy living. Now I have a better quality of life and that is awesome!! Thank You Ladies!!”

Community Demographics

- Ypsilanti, Michigan (2021)
  - Population 20,113
    - White 60%
    - Black or African American 27%
    - Hispanic 7%
    - Two or more races 6%
  - Persons in poverty 29.7% (13% for MI)

Trinity Health

Community Health Needs

- **Mental health and substance use disorders**
- **Obesity and related illnesses**
- Pre-conceptual and perinatal health

Trinity Health

Health Disparities and Food

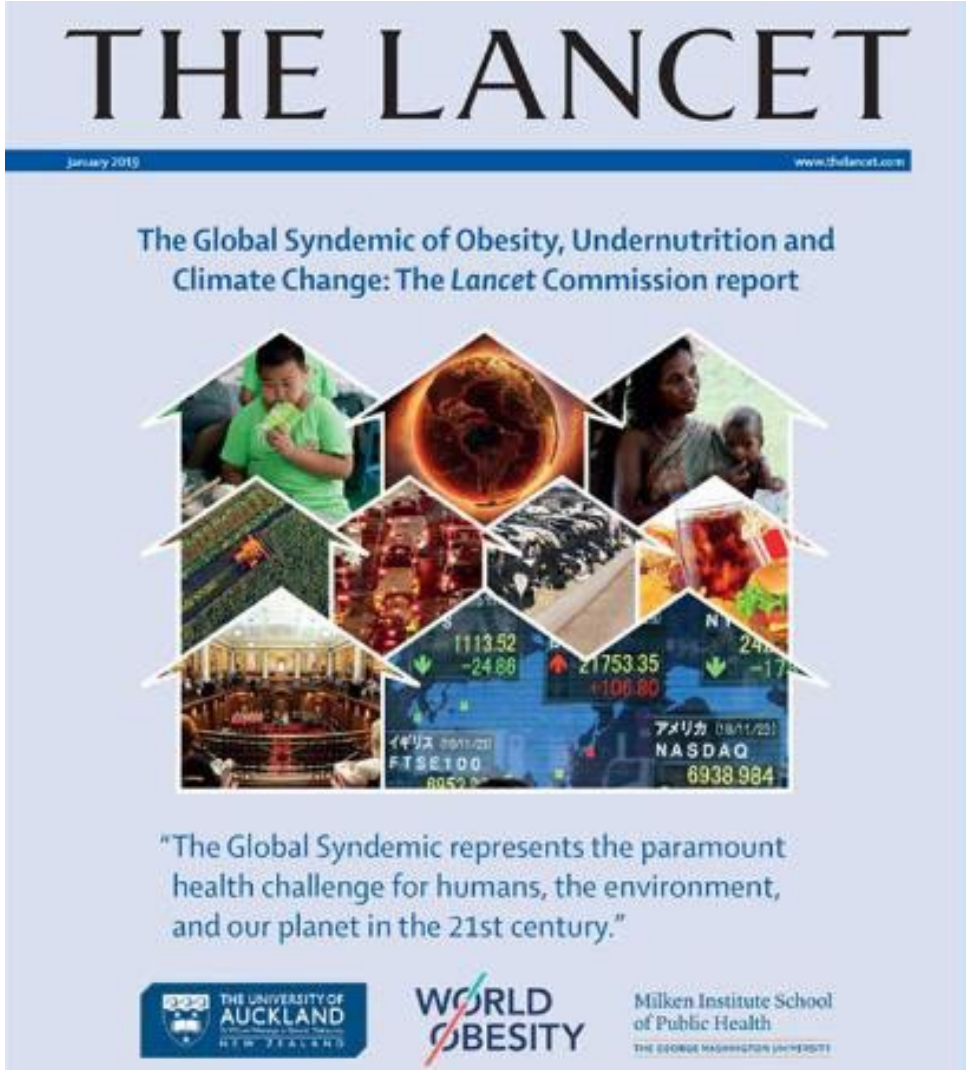
- Food is the number one cause of poor health in America.
- Poor diet is the cause of 500,000 deaths/year.

Trinity Health

Life expectancy in the United States, mapped by neighborhood — Quartz (qz.com)

What's driving poor diet (malnutrition)?

- Hunger
- Lacking sufficient nutrients
- Overweight and obesity
  - Food insecurity

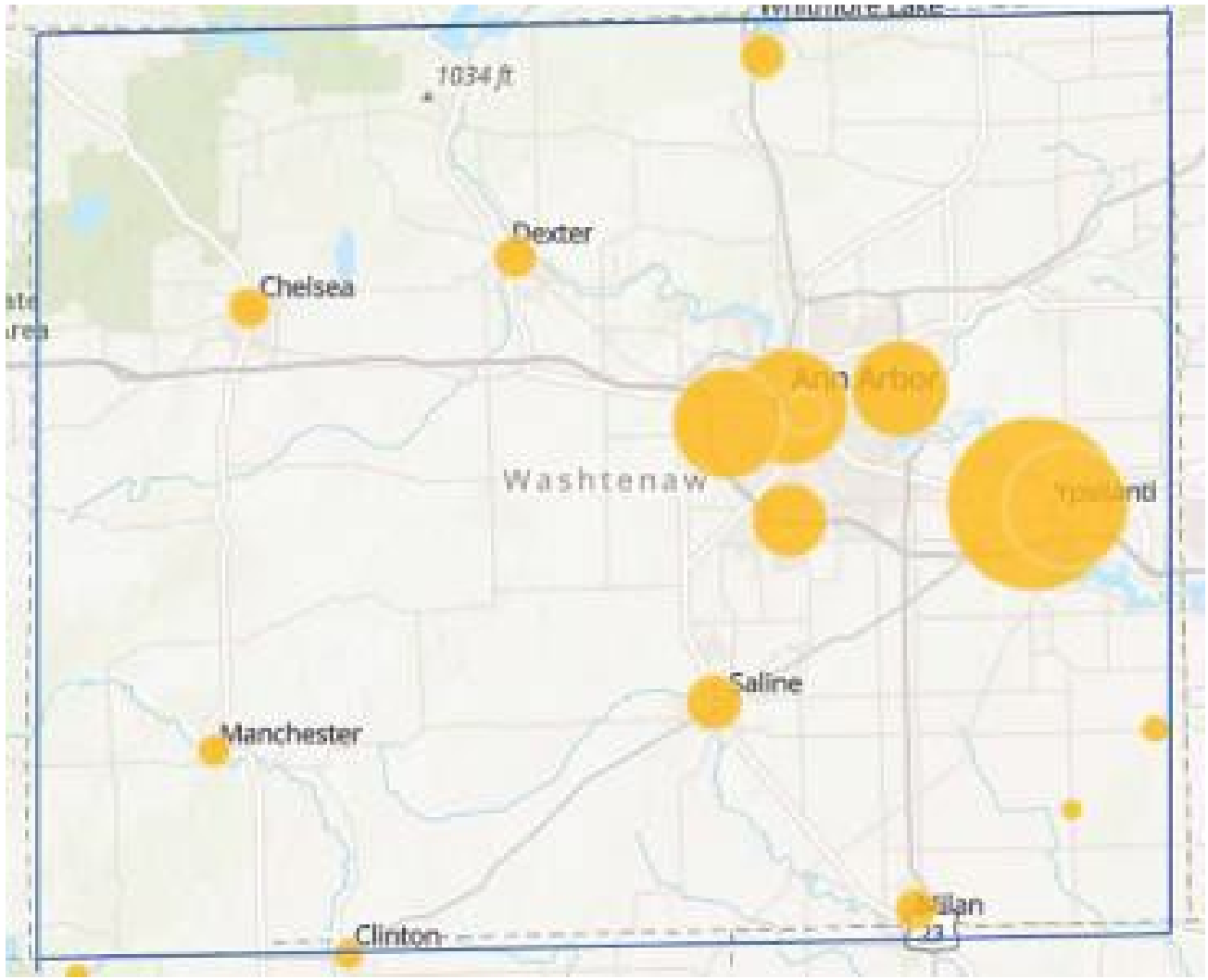


Trinity Health

Food Insecurity is More Prevalent in Black, Indigenous, People of Color, and Low-Income Communities

- 48197 – 12,100 (18% of pop)
- 48198 – 8,110 (21% of pop)
- 48104 – (18% of pop)
- 48103 – (13 % of pop)

Food insecurity increased 36% in 2020.



Data and image from Food Gatherers

What Else is Contributing to the Dietary Gap?

Differences in food access account for 10% of the dietary gap.

What else is contributing?

- Cost
- Emotional nutrition
- Time budgets
- Belonging
- *Check out "How the Other Half Eats" by Priya Fielding-Singh*

Junk food marketing to kids: four facts that will blow your mind | MomsRising

Who Created Frozen Pizza? | Wonderopolis

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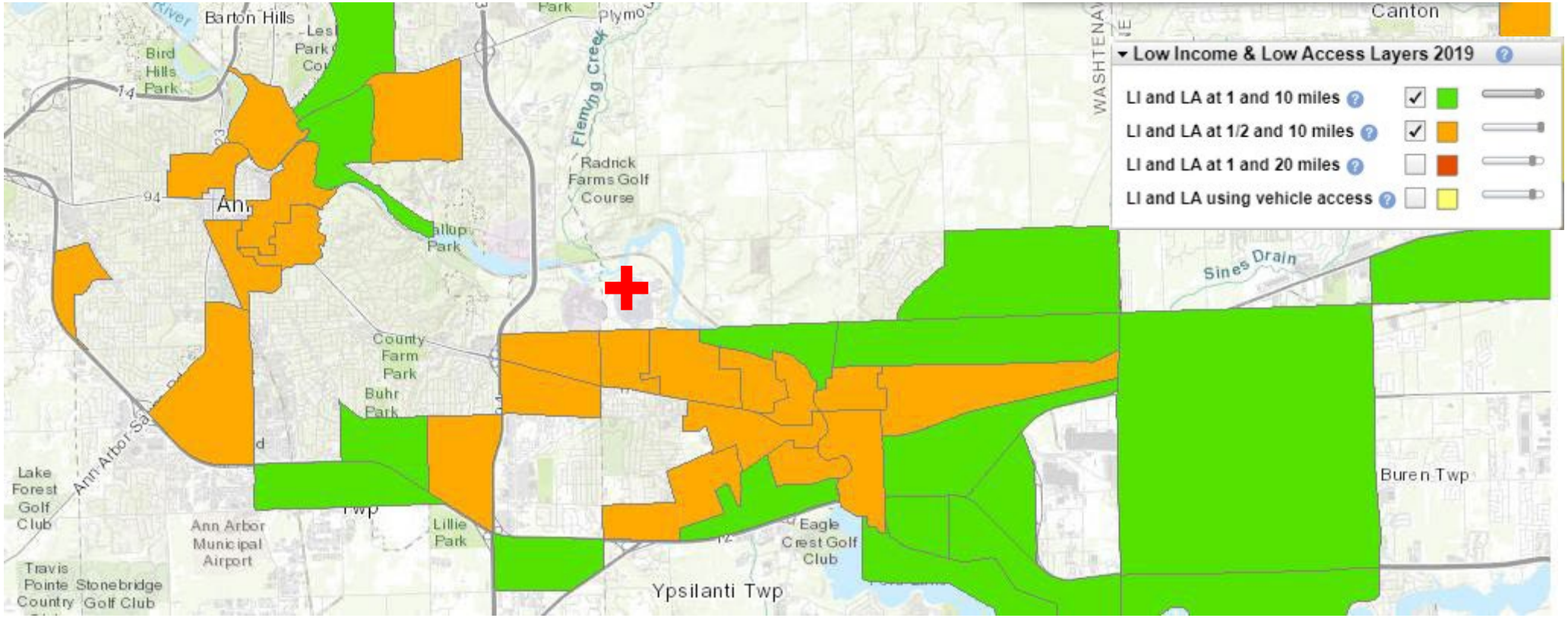
Food Access is Uneven



Food Apartheid: A preferred term to Food Desert because it highlights the political reality of food insecurity. Food and agriculture is deliberately not made available to specific communities (for example black, brown, low-income, & indigenous communities)

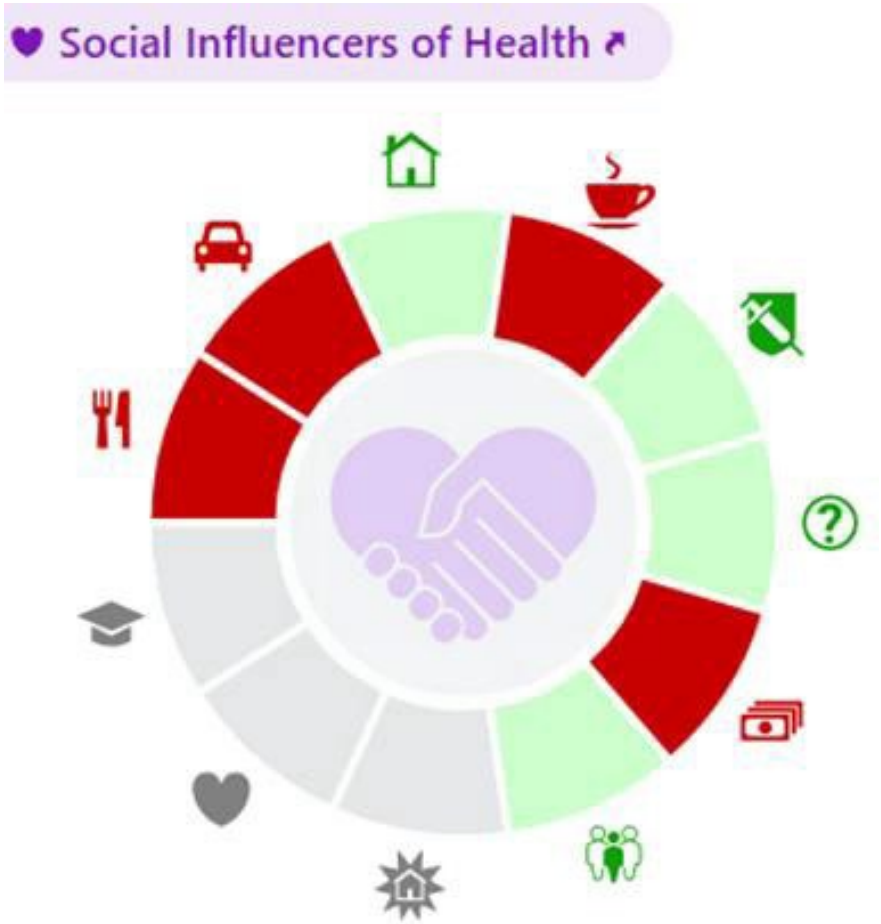
Trinity Health

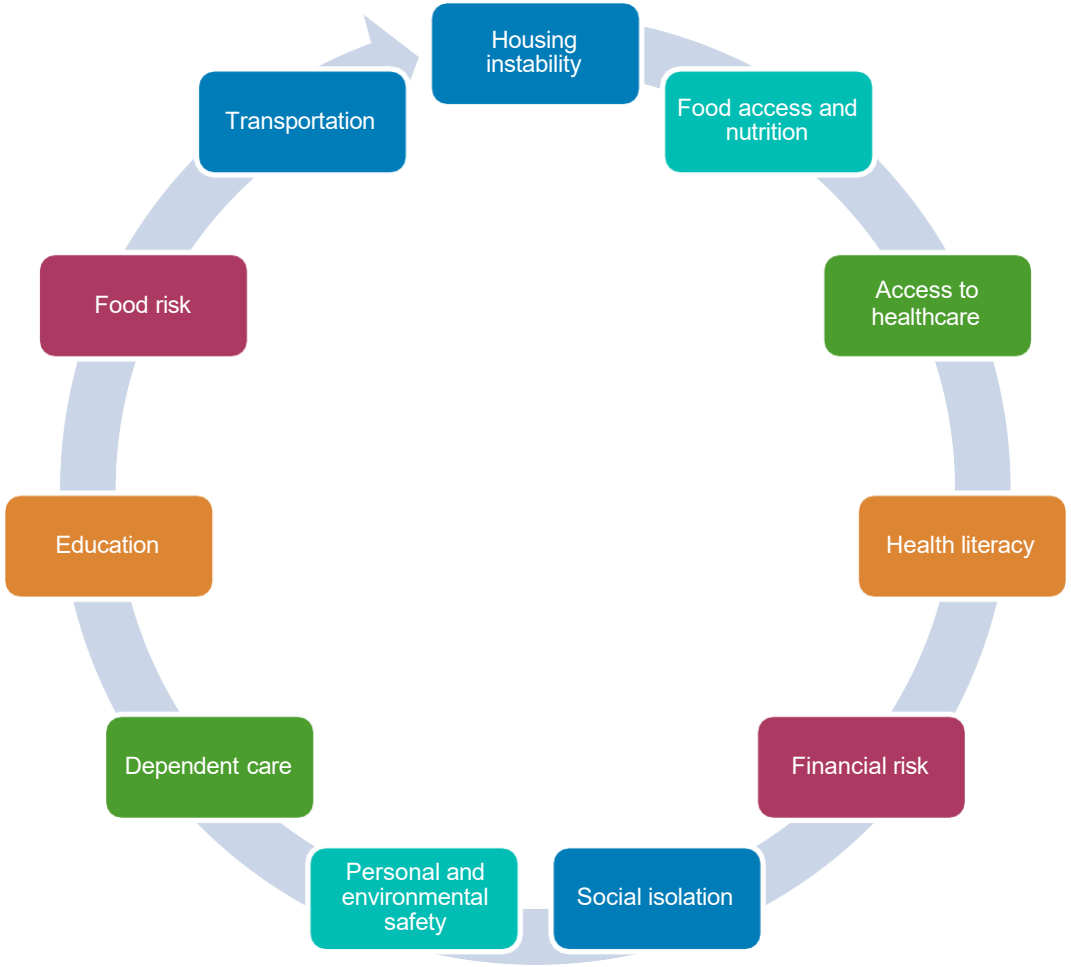
The Food Access Research Atlas guide (usda.gov)

Social Determinants of Health

- Economic Stability
- Education Access and Quality
- Health Care Access and Quality
- Neighborhood and Built Environment
- Social and Community Context

Trinity Health Social Influencers of Health

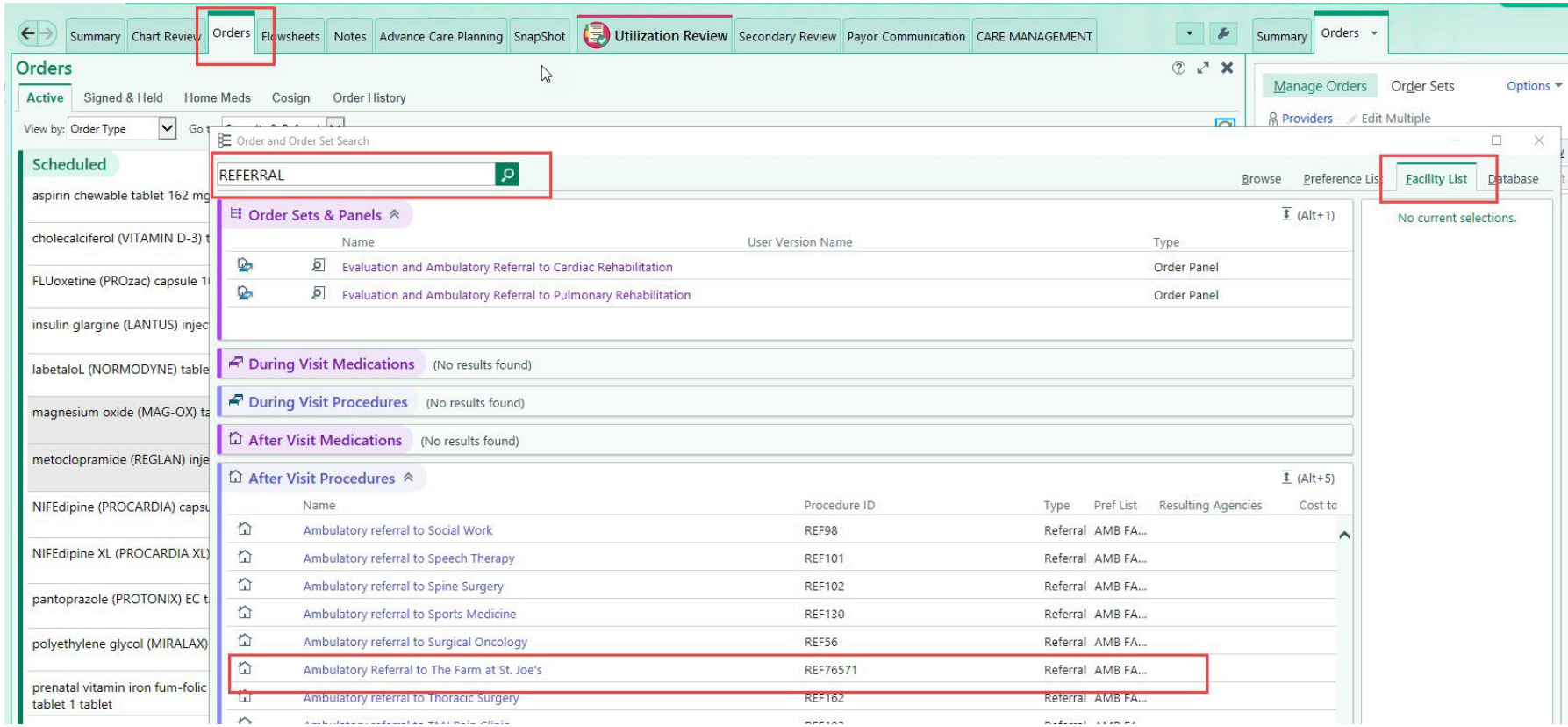




Trinity Health

Provider referral via Together Care to the Farm Share

1. Patients screen positive for food insecurity through the SIOH questions
2. Make ambulatory referral to The Farm.

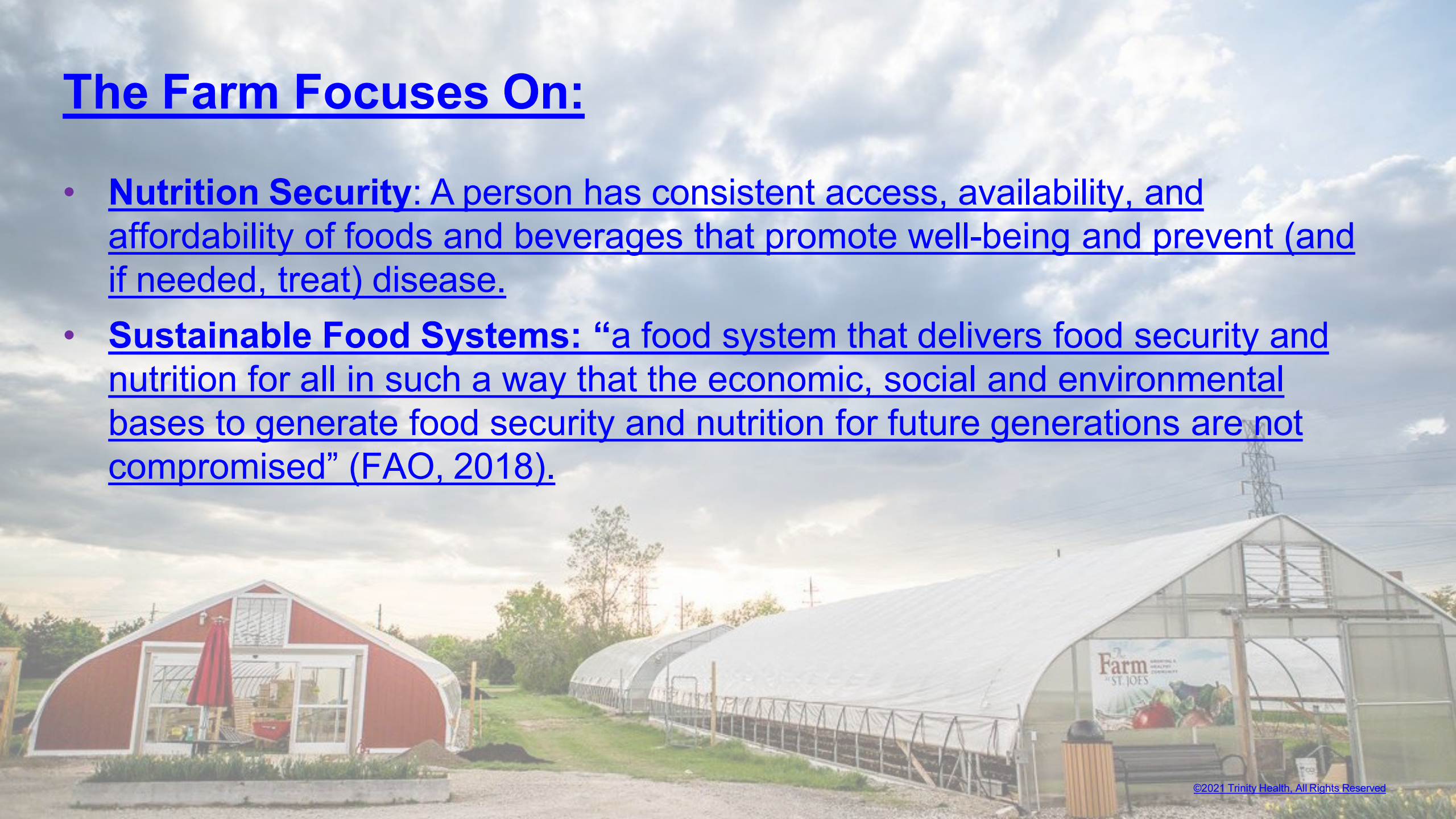


The Farm at Trinity Health

Growing a healthy community by empowering people through food, education and relationships.

The Farm Focuses On:

- **Nutrition Security**: A person has consistent access, availability, and affordability of foods and beverages that promote well-being and prevent (and if needed, treat) disease.
- **Sustainable Food Systems: "**a food system that delivers food security and nutrition for all in such a way that the economic, social and environmental bases to generate food security and nutrition for future generations are not compromised" (FAO, 2018).



Trinity Health- Ann Arbor

- Started 2010
- 2 production hoop houses
- ADA hoop house
- Propagation hoop
- 4 acres
- Barn
- Food hub
- Classroom/teaching kitchen
- Outdoor classroom
- Community garden

Where We Are Today

Ann Arbor

Oakland

Trinity Health

Our Impact is Growing

2010-14	2015	2016	2017	2018	2019	2020	2021	2022
Farm Market	Farm Share	Farm Share	Farm Share	Farm Share	Farm Share	Farm Share	Farm Share	Farm Share
Pre-k visits	Farm Market	Farm Market	Farm Share Assistance	Farm Share Assistance	Farm Share Assistance	Farm Share Assistance	Farm Share Assistance	Farm Share Assistance
Produce donations	Youth Field Trip program	YCS Field Trip Program	Farm Market	Farm Market	Farm Market	Full-time interns	Full-time interns	Farm Market
	Community garden	Cooking classes	Cooking classes	Cooking classes	Cooking classes	Produce to Patients	Produce to Patients	Good Food Box
		Summer camp	Full-time interns	Full-time interns	Full-time interns	COVID Food Assistance	Summer camp	Full-time interns
		Community Garden	YCS Field Trip Program	YCS Field Trip Program	YCS Field Trip Program	Bright Futures	Bright Futures	Produce to Patients
		Compassion Garden	Summer Camp	Summer Camp	Summer Camp	Market Connection	Market Connection	Summer camp
			Community Garden	Events	Events	Community Garden	Horticultural Therapy	Bright Futures
			Compassion Garden	Community Garden	Produce to Patients	Compassion Garden	Community Garden	Horticultural Therapy
				Compassion Garden	Community Garden	Virtual classes	Compassion Garden	Community Garden
					Compassion Garden		Virtual classes	Compassion Garden
								Virtual classes
								Staff retreats

Investing in Nutrition Security

Farm Market

- Re-opened in 2022
- Increasing access and convenience for providers and patients

Trinity Health

Produce to Patients and Providers

- 80% of the food grown at the Farm is donated (10,000 lbs. in 2021).
- Providers pick up produce to distribute to patients.
- Colleagues were added in 2020.

Trinity Health

Collaborative Farm Share

14+ local farms

The Farm at Trinity Health

Farm Share Members & Farm Share Assistance Members

Collaborative Farm Share Goals

Goals

- Economic – provide consistent revenue source for local and Michigan farms
- Social – provide access to high quality local food to food insecure families; increase social cohesion
- Nutritional – increase fruit and vegetable consumption among members and knowledge on how to prepare a wider variety of veggies

<u>2021 Highlights:</u>

- **$180,349** went to 14 local farms
- **8,480** total produce boxes packed
- **100** food insecure families received free membership

Trinity Health

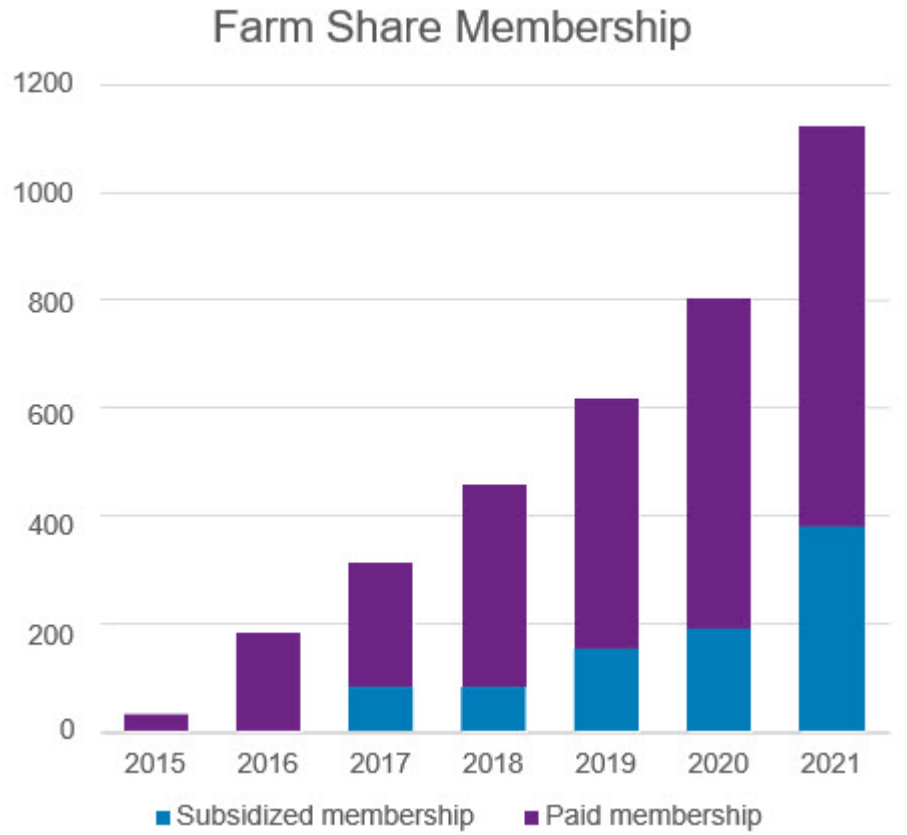
Farm Share Assistance

≥ 25% of our members receive free or reduced cost membership because they are experiencing food insecurity

<u>Program totals: since 2015</u>

- 802 food insecure families served
- Donated $223,000 of produce

Food Hub and the Farm Share



Farm Share Assistance Program – Impacts

- 80% of participants increased their intake of fruits and vegetables
- As a result of this program children:
  - 100% ate more fruits and vegetables
  - 100% tried new fruits and vegetables
  - 86% requested fruits or vegetables to be included in a snack or meal

Good Food Box

Who:

1. Experiencing food insecurity
2. Dually enrolled in Medicare and Medicaid
3. Live in Washtenaw Co. or Bellville

Intervention:

1. Every other week delivery of local produce and healthy pantry staples
2. One-time delivery of a starter kit with recipes, cutting board, knife, spices, oil etc.
3. Support from Community Health Worker

How:

1. Partnership with Jewish Family Services and Food Gatherers
2. Funded by Trinity grant dollars and local philanthropy

Pick-up Options

Investing in the Sustainable Food Systems

- 2022 will generate >$250,000 for local farms
- Total since 2015: >$800,000

Learn more!

Website: www.stjoesfarm.org

Follow us on social media:

- Facebook and Instagram

Reach out:

Amanda.Sweetman@trinity-health.org

Fresh Food Pharmacy Pilot Program

Overview and Lessons Learned

DPAC Forum

November 3, 2022

Amanda Feighner, MS, RDN

grace HEALTH

food BANK COUNCIL OF MICHIGAN

SOUTH MICHIGAN FOOD BANK

Overview

- Community Partners
- Program Model
- Evaluation and Lessons Learned
- Additional Resources

Funding Acknowledgement

Michigan Health Endowment Fund

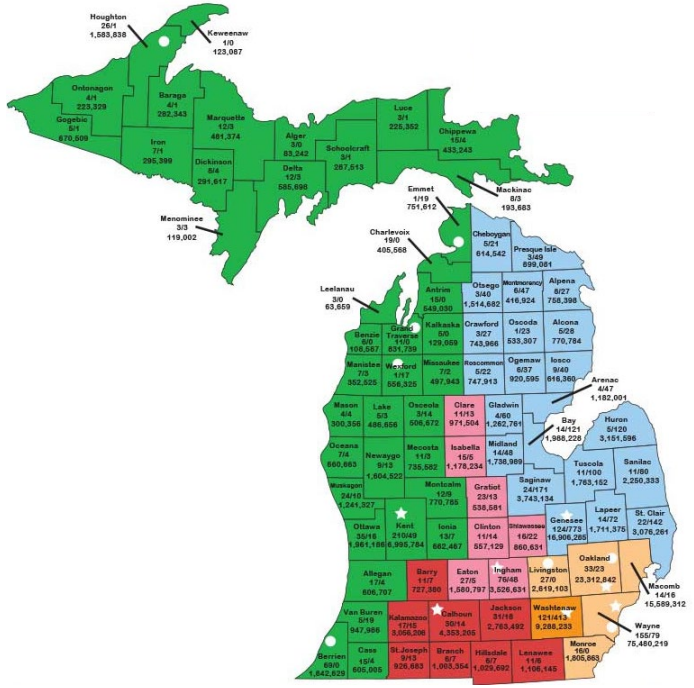
Nutrition and Healthy Lifestyles

Community Partners

Food Bank Council of Michigan

Mission: The Food Bank Council of Michigan's mission is to create a food secure state through advocacy, resource management, and collaboration among stakeholders and Michigan's unified food bank network.

food BANK COUNCIL OF MICHIGAN



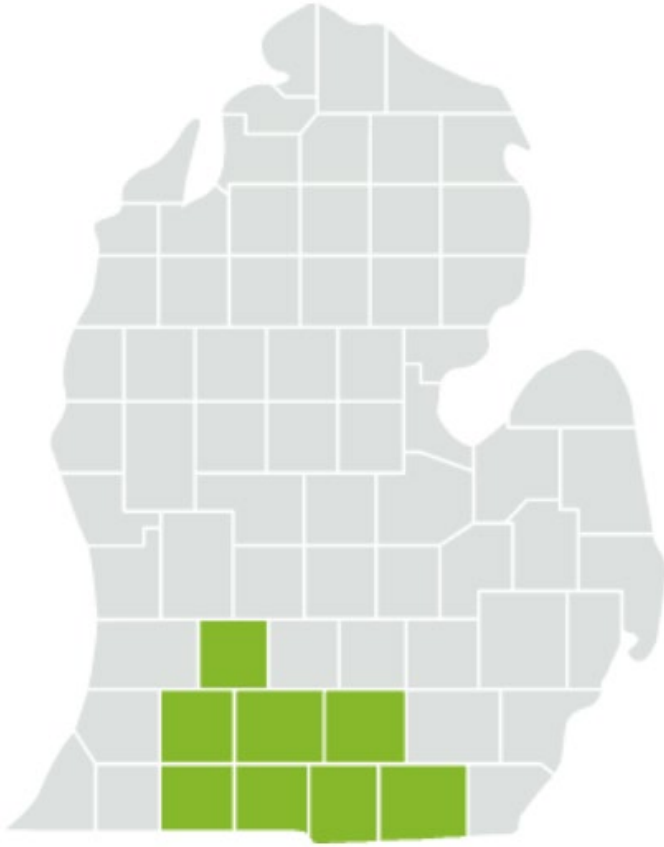
Grace Health

- Federally Qualified Health Center (FQHC) in Battle Creek and Albion
- Mission: To provide patient-centered healthcare with excellence in quality, service, and access.

grace HEALTH

South Michigan Food Bank-Location

- Founded 1982
- 1 of 7 food banks in Michigan
- Provide foods to over 300 partner agencies across 8 counties
- Mission: To enhance the quality of life for those struggling with hunger in South Michigan.



South Michigan Food Bank

So, here's our part in the movement to end hunger

SECURE DONATIONS

ACQUIRE & MOVE FOOD

SAFELY STORE & DISTRIBUTE FOOD

PARTNERS OPEN THEIR DOORS

TOGETHER, WE FEED THOUSANDS OF PEOPLE

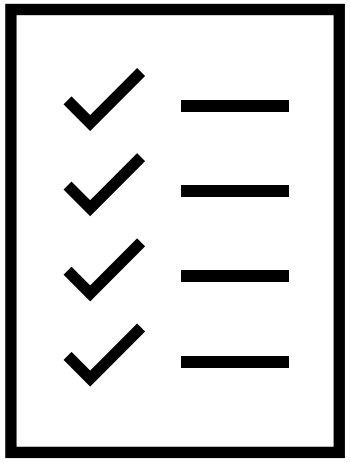
Fresh Food Pharmacy Program Model

Fresh Food Pharmacy Pilot Overview

- Pilot: March 2021 – Dec 2022
- Qualifying patients at Grace Health
  - 302 enrolled
- Nine-month program
  - Supplemental food
  - Health coaching
  - Evaluating behavior change and health outcomes

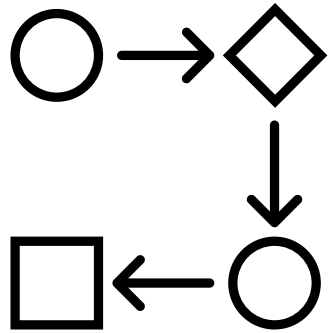
Evaluation Overview

- Biometrics
  - Blood Pressure
  - A1C (diabetes and pre-diabetes)
  - Weight
- Surveys
  - Monthly Check Ins
  - Pre and Post
  - Select Qualitative Interviews



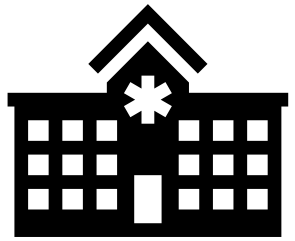
Program workflow

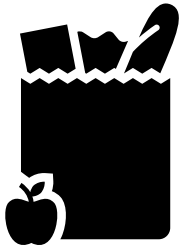
- Patient identified and referred
- Screened for eligibility
- Nurse visit with pre survey and biometrics
- Food bank schedules food delivery / pick up
- Clinic schedules first monthly appt assessment
- Continue onward with 9 months appts and food
- Schedule for post nurse visit – survey and biometrics



Staffing

- Grace Health
  - Healthy Lifestyles Coaching Team
    - Registered Dietitian
    - Additional Coach
  - Resource Specialist
  - Additional Clinic Staff (scheduling, management, nurses, providers)
- Food Bank
  - Nutrition Programs Manager
  - Data Coordinator
  - Driver
  - Operations and Warehouse staff





Patient Eligibility and Expectations

- Eligibility
  - Food insecure
  - Willingness and ability to prepare foods and participate in coaching
  - Not receiving dialysis
  - Nutrition related condition
    - Diabetes
    - Pre-Diabetes
    - Gestational Diabetes
    - Heart Disease
    - Hypertension
    - BMI over 30
- Graduation requirements – miss only 5 contacts (combination of food and coaching)

Kick off Kit

- Recipe Book
- Spices for recipes
- Olive oil
- Kitchen supplies
  - Chef Knife
  - Colander
  - Food Storage Containers
  - Vegetable Peeler

Food Boxes Contents

- 25-30 lbs of food
- Double boxes for larger families
- Frequency – biweekly
- Delivery or Pick-Up
- Choices
  - 6 boxes – cycle through choices
  - 2 boxes fully vegetarian
  - 2% dairy or almond milk
- Boxes
  - Ingredients for 2 recipes
  - Plus milk, cereal, eggs, fruits and veggies
- Food Sourcing

Recipe Example

- Health Focused Recipes
  - Fruits and vegetables
  - Lean protein (chicken breast and ground turkey)
  - Reduced sodium canned goods (when possible)
  - Whole grain pasta (when possible)
  - Suitable for multiple nutrition related health conditions

Cooking Matters

Turkey Tacos

Serves 8, 2 tacos per serving
These recipe ingredients are found in Box A1

Ingredients

- 1 medium carrot, small sweet potato, or small zucchini
- ¼ medium head lettuce
- 2 large tomatoes
- 4 ounces low-fat cheddar cheese
- 1 (15½-ounce) can low-sodium pinto beans
- Non-stick cooking spray
- 1 pound lean ground turkey
- 1 (15½-ounce) can chopped or crushed tomatoes, no salt added
- 1 Tablespoon chili powder
- 1 teaspoon garlic powder
- 1 teaspoon dried oregano
- ½ teaspoon salt
- ½ teaspoon ground black pepper
- 16 taco shells

Directions

1. Rinse, peel, and grate carrot, sweet potato, or zucchini (if using zucchini, grate but do not peel). Squeeze dry with paper towels.
2. Rinse and shred lettuce. Rinse, core, and chop tomatoes.
3. Grate cheese.
4. In a colander, drain and rinse beans.
5. Coat a large skillet with non-stick cooking spray. Heat over medium high heat. Add turkey and brown.
6. Add veggies, beans, canned tomatoes, an spices. Stir well.
7. Reduce heat to medium. Cook until thickened, about 20 minutes.
8. Add 2 Tbsp cooked meat mixture to each taco shell. Top each with 1 Tbsp grated cheese, 1 Tbsp shredded lettuce, and 1 Tbsp fresh tomatoes.

Notes

Top tacos with any of your favorite veggies, hot sauce, salsa, low-fat sour cream, or low-fat plain yogurt. Use any type of cooked beans you like. For more heat, add minced hot peppers to sauce in step 6.

Recipes by Box

A1	**Turkey Tacos & Black Bean Vegetable Soup**
A2	**Baked Flaked Chicken & Turkey Burger Macaroni**
A3	**Frittata & Vegetable Lasagna**
B1	**Turkey Burger & Mexican Lasagna**
B2	**Tex Mex Skillet & Hearty Egg Burrito**
B3	**Barley Lentil Soup & Pasta with Beans and Greens**

Food Boxes


meijer
FAMILY SIZE
TOASTED OATS
Whole Grain Oat Cereal
UNSWEET
Silk
ALMOND
HONEYSUCKLE WHITE
meijer
BLACK BEANS
PROVIDED BY:
SOUTH MICHIGAN FOOD BANK
meijer
GOLDEN SWEET CORN
meijer
BLACK BEANS
meijer
BLACK BEANS
jumbo
GRADE A EGGS
meijer
REDUCED FAT
COLBY JACK
SHREDDED

Healthy Lifestyles Coaching Program

- Two staff
  - Registered Dietitian – Diabetic patients
  - Healthy Lifestyles Coach – other patients
- Initial assessment
- Focus on individual patient goals each month

Graduation

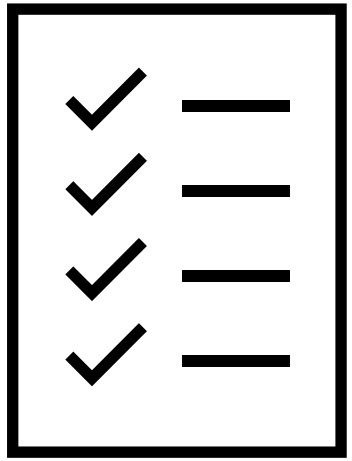
- Nurse Visit
  - Post survey
  - Post biometrics
- Patient gifts
  - Branded water bottle
  - $20 Meijer gift card
  - Certificate

FRESH FOOD PHARMACY

Evaluation and Lessons Learned

Survey Questions

- Pre-Survey
  - Diet Quality and Behavior – Fruits and Vegetables
  - Chronic Disease Self Management
- Post-Survey
  - Pre-Survey questions
  - Food Security
  - Food Box and Coaching Improvement and Use
- Monthly Check-Ins
  - Food usage
    - Percentage
    - Menu changes
    - Reasons for not using food
  - Healthy days
    - Physical health
    - Mental health

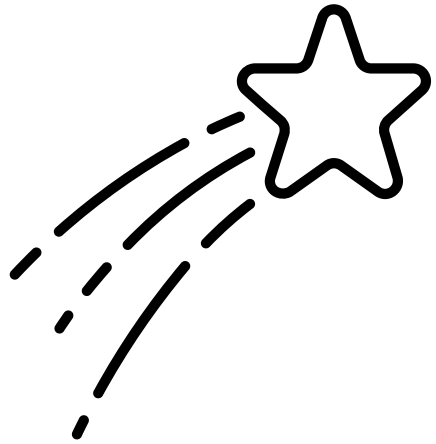


Evaluation Consultants

- Pilot ends December 2022
- NORC at the University of Chicago
- Expect to graduate ~50% of patients

Patient Success

- Many patients asking to sign up again
- Reports of
  - lowered A1C and weight loss
  - Increased movement
  - Trying new foods
  - Eating more consistently nutritious meals
  - Enjoying recipes
  - Feeling better mentally and physically



Patient Success - Case Study 1

- In 4 months, A1C improved
- Tries new foods she would not normally purchase
- Exercises more
- Loves eating more fresh fruits and vegetables
- Eating more consistently
- Favorite recipe – Egg Burritos

Patient Success - Case Study 2

- More aware of nutrition
- Historically did not cook, but has increased confidence in this program
- Health coach helps with ideas to modify foods to reduce sodium and still taste great – now uses spices
- Before program was retaining water and finding it difficult to move
- Blood pressure and mobility improved
- Believes lessons learned will serve him for the rest of his life, well beyond the program ending
- Favorite recipes: Turkey Tacos, Lasagna, Baked Flaked Chicken

Lessons Learned and Challenges 1

- Sourcing Challenges
  - Supply chain - COVID
- Foods Offered
  - More variety over choice
  - Most dedicated patients - fatigued with foods and recipes
  - Recipe option was very helpful for some
- Amount of Foods
  - Reduce size of boxes (especially for seniors)
  - Uniform model is challenging (health conditions, family size, etc)
- Food Distribution
  - Home delivery – screening in future for need
  - Pick-up – many patients prefer flexibility

Lessons Learned and Challenges 2

- Education
  - Not appropriate for all patients
  - Different offerings – group and individual
- Case Management
  - Significant staff time
- Screening
  - Refining screening questions or method in which delivered
- Program guidelines
  - Best way to communicate to patients
- Retention
  - Expect to graduate about 50%
  - Modify education requirements

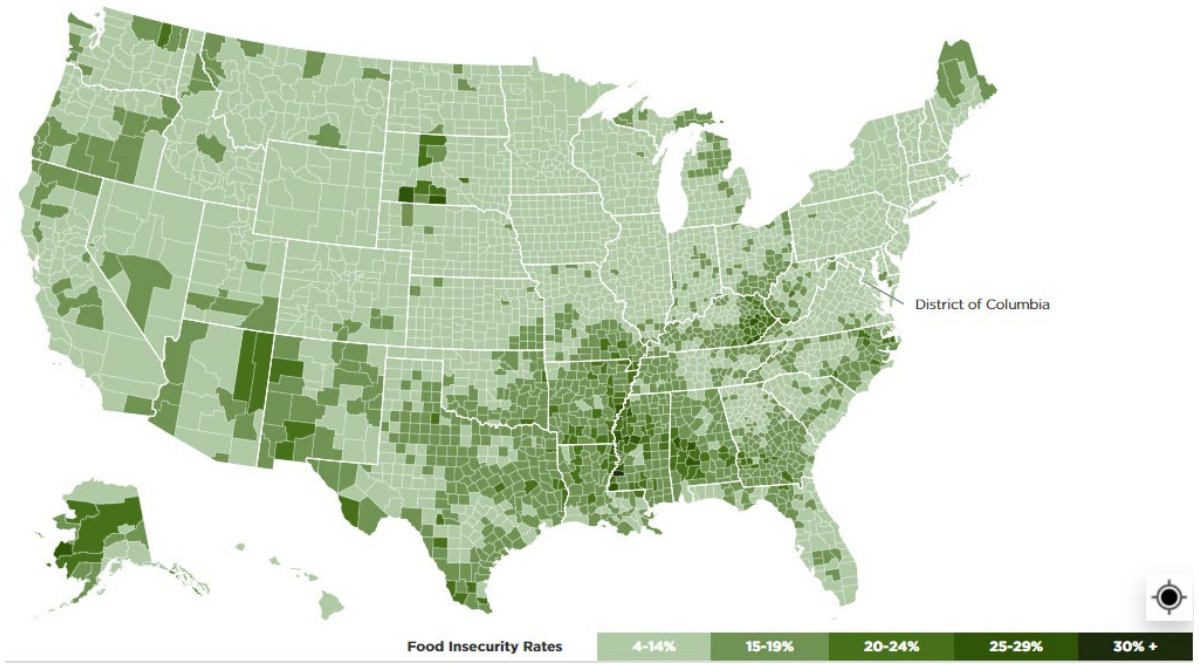
Next Steps – Pilot 2.0

- Additional Michigan Health Endowment Fund Grant
  - Refine model – suite of offerings
    - Group support
    - Optional coaching
    - Food only option
- Sustainability in funding

Resources to Explore

Feeding America Related Resources

- Map the Meal Gap
  - https://map.feedingamerica.org/



Food Bank Recipient National Health Survey

- Hunger in America Survey found 47% of food bank clients reporting “fair” or “poor” health
- Nationally food bank client households have
  - 33% with at least one member with diabetes
  - 58% with at least one member with hypertension
- 29% of households report no health insurance coverage including Medicaid or Medicare
- 55% have unpaid medical bills
- 66% have to choose between paying for medicine/ medical care or food in the past year
  - 31% face this decision monthly

1. Food Banks as Partners in Health Promotion: Creating Connections for Client and Community Health. Feeding America and Center for Health Law and Policy Innovation of Harvard Law School. https://hungerandhealth.feedingamerica.org/wp-content/uploads/legacy/mp/files/tool_and_resources/files/food-banks-as-partners-in-health-promotion-creating-connections-for-client-community-health.pdf

Questions?

Contact Information

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amanda@smfoodbank.org

References and Resources

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2. Feeding America Hunger and Health – Community and Health Care Partnerships Website https://hungerandhealth.feedingamerica.org/explore-our-work/community-health-care-partnerships/
3. Food Banks as Partners in Health Promotion https://chlpi.org/wp-content/uploads/2013/12/Food-Banks-as-Partners_HIPAA_March-2017.pdf
4. Food Insecurity and Health: A Tool Kit for Physicians and Health Care Organizations https://hungerandhealth.feedingamerica.org/wp-content/uploads/2017/11/Food-Insecurity-Toolkit.pdf


#TAKE
CARE OF
YOURSELF

Chronic Illness, Mental Health, And Suicide

Kristen Smith, PhD, LMSW

Program Coordinator- Preventing Suicide In Michigan Men

Michigan Department Of Health And Human Services

Agenda

1. Review the intersection between chronic illness and mental health
2. Review relevant data related to suicide, suicide related behavior, and chronic illness
3. Review available resources for individuals experiencing worsening mental health due to chronic illness

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Chronic Illness Drain

Stressors:

- **Physical**
- Emotional
- Financial

Mental Health and Mood Disorders

People with other chronic medical conditions are at higher risk of depression.

- Trouble coping with symptoms
- Hopeless feeling/pessimistic
- Changes in appetite
- Physical symptoms
- Increase in substance use
- Thoughts of Suicide

People with depression are at higher risk for other medical conditions.

- Challenges caring for physical health
- Internal systems change that impact physical symptoms

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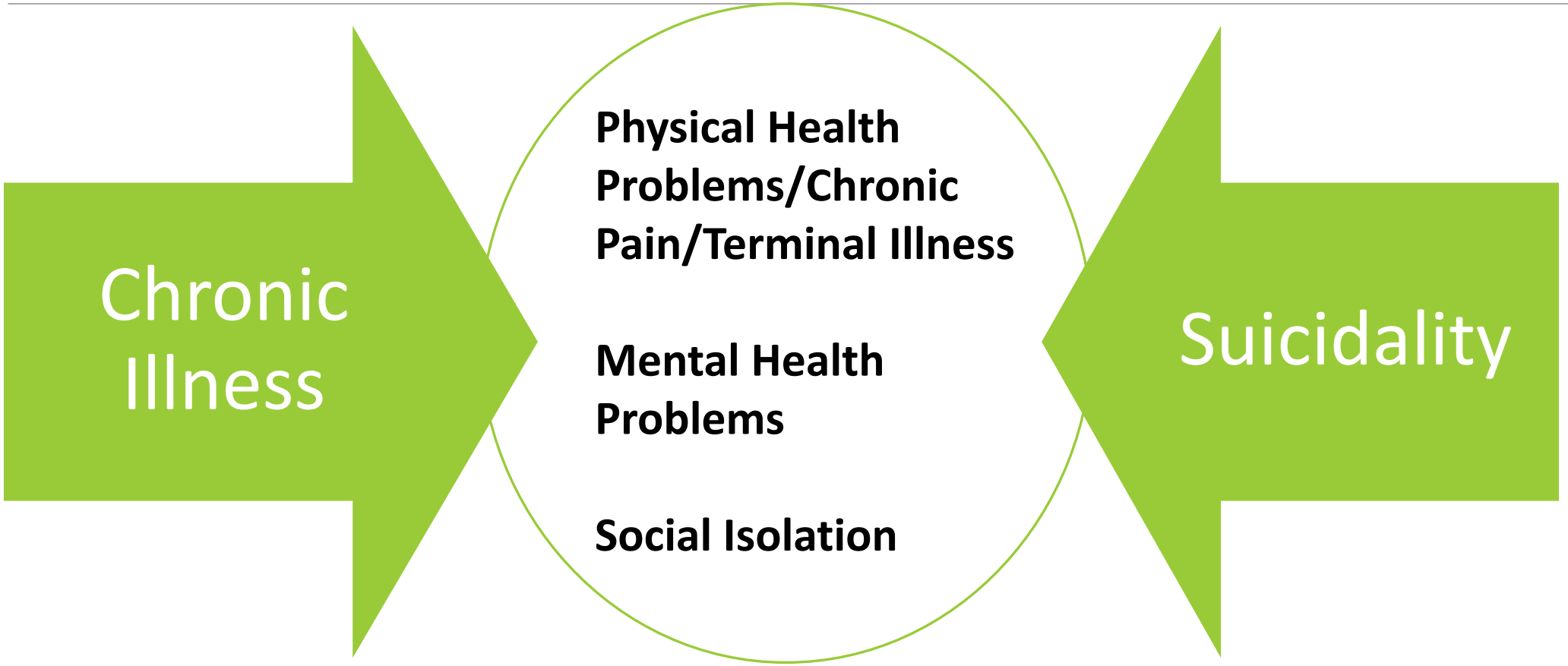
Why talk about suicide in healthcare settings?



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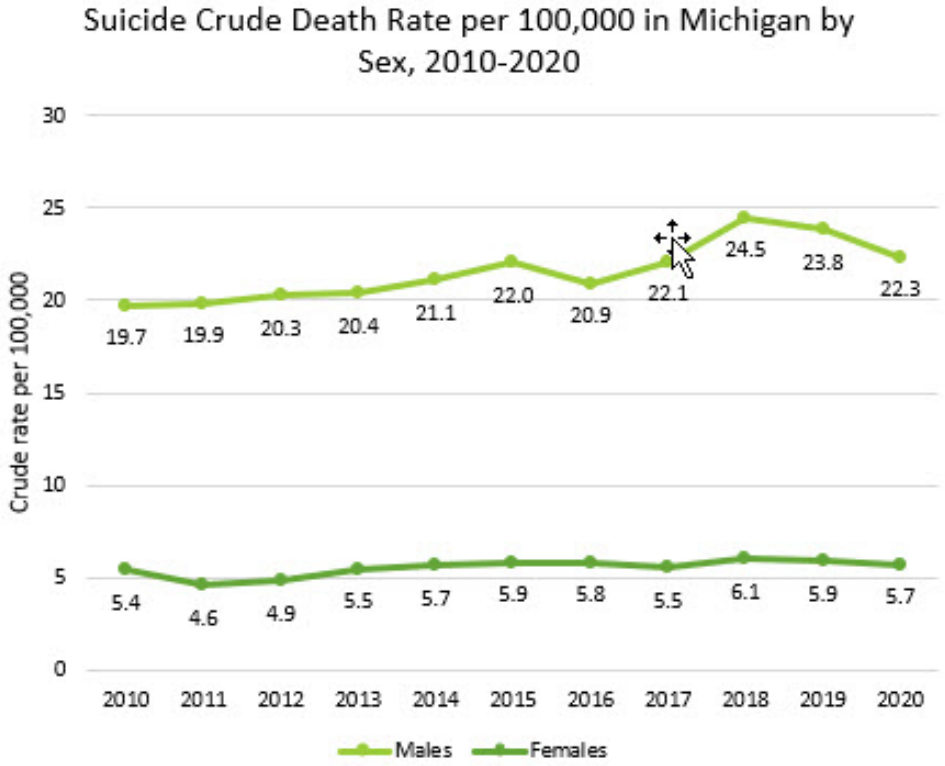
Suicide Risk

Facts About Suicide

- Men are at higher risk to die by suicide
- Women are more likely to attempt suicide
- Over half of the deaths related to suicide involve a firearm
- It is the 10th leading cause of death nationally
- Chronic illness is just one risk factor related to suicide risk
- Risk can't be determined by one circumstance
- It is necessary to talk to your patients/loved ones about suicide
- Anyone can be at risk- consistent screening is important



SOURCE: MICHIGAN VIOLENT DEATH REPORTING SYSTEM, 2020

Demographic Factors

Access to quality care

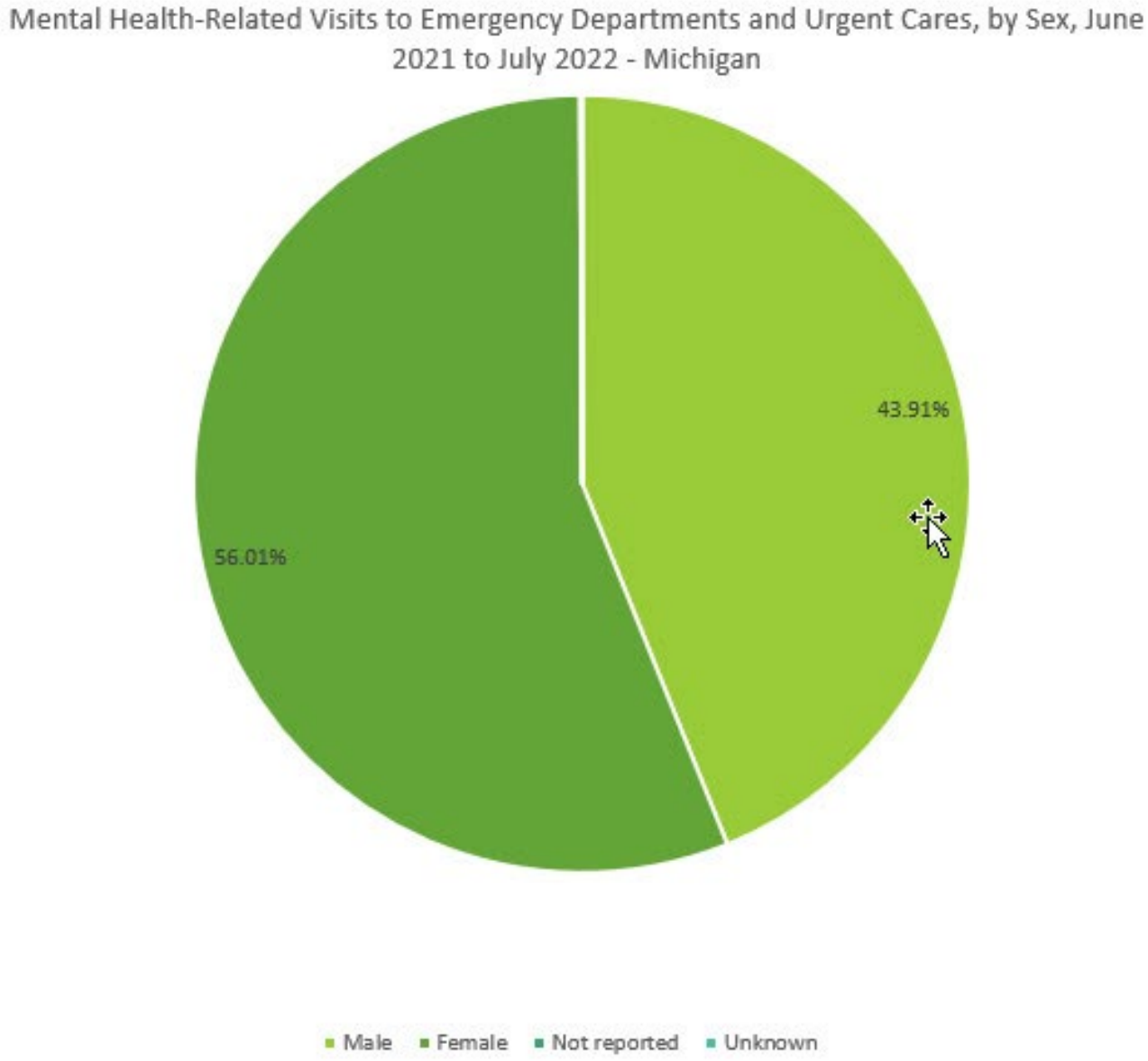
Low income/education

Race/ethnicity differences

Age (suicide rates and chronic illness rates rise in old age)

Location

Stigma associated with chronic disease AND mental health

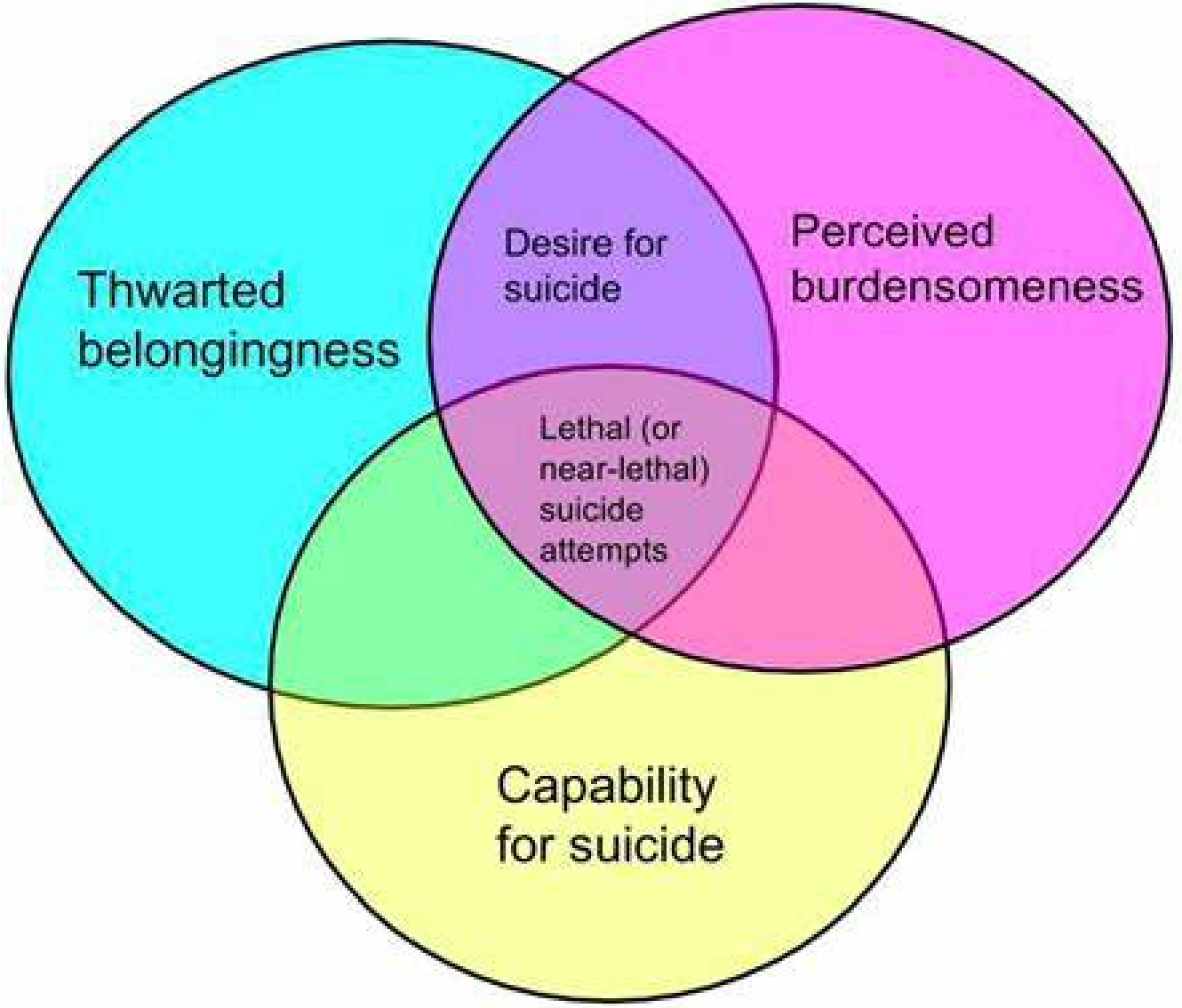


Data Source: National Syndromic Surveillance Program (NSSP)

Suicide Risk

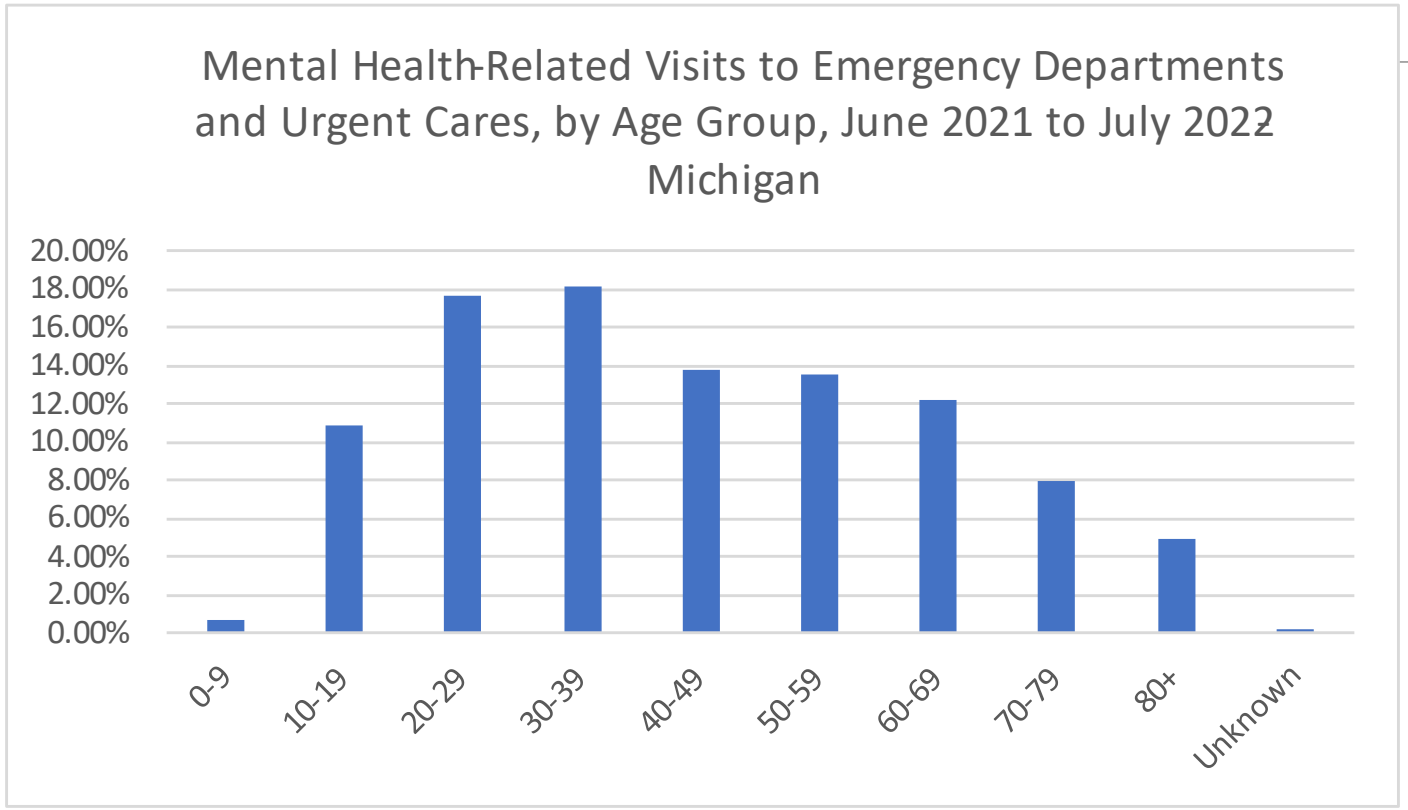
Warning Signs

- Increased substance abuse
- Purposelessness
- Anxiety
- Hopelessness
- Withdrawal
- Mood changes



SOURCE: THOMAS JOINER, 2007

Health System Visits



- 84% of those who die by suicide have a health care visit in the year before their death.
- 92% of those who make a suicide attempt have seen a health care provider in the year before their attempt.
- Almost 40% of individuals who died by suicide had an emergency department (ED) visit, but not a mental health diagnosis.

SOURCE: AHMEDAHNI, 2014; AHMEDAHNI, 2015 DATA SOURCE: NATIONAL SYNDROMIC SURVEILLANCE PROGRAM (NSSP)

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So What?

Suicide Prevention is Everyone's Business

- Consider risk factors for both physical and mental health conditions
- Engage health systems and physical health practitioners in this conversation
  - Establish systems to ensure patient safety
- Ask!
- Assess!
- Make a plan!
  - Outpatient behavioral health providers, 988, safety plan, reduce access to lethal means

Recognizing and Treating Depression

Suicide Prevention Telehealth Toolkit

Man Therapy Michigan

SPRC Training and Webinars

Linked Resources

Questions?

smithk134@michigan.gov

NATIONAL DIABETES MONTH

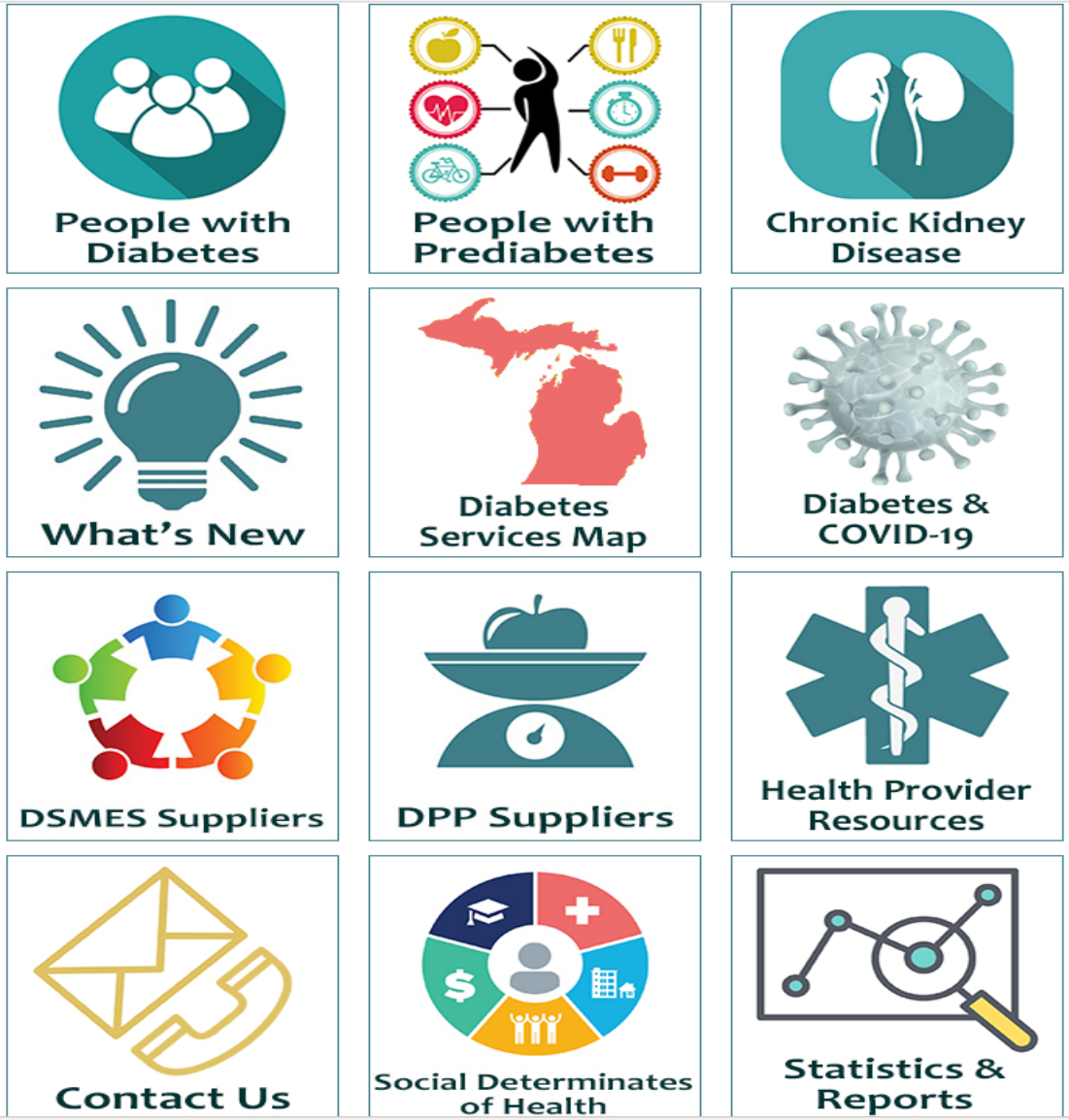
#DiabetesMonth

#ForwardAs1

#DiabetesHitsDifferent

MDHHS DIABETES PREVENTION AND CONTROL PROGRAM

OUR WEBSITE HAS A NEW LOOK



visit Michigan.gov/diabetes or scan the QR code for more information

LUNCH

National Diabetes Month

American Diabetes Association

Gary Dougherty
Director, State Government Affairs

gdougherty@diabetes.org

MDHHS Diabetes Prevention Policy Update

Tamah Gustafson, MPH, CHES, CPH
Diabetes Prevention Coordinator, MDHHS
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Take It to Heart: SGLT2 Inhibitors and Cardiovascular Outcomes in Diabetes

Corey Rowe, Pharm. D.
Michigan Pharmacists Association

Diabetes Partners in Action
November 2022

Learning Objectives

- **Understand the mechanism of action** of SGLT2 inhibitors and their role in diabetes treatment.
- **Describe the cardiovascular benefits** of SGLT2 inhibitors in patients with Type 2 Diabetes.
- **Describe the role of the pharmacist** in managing the care of these patients.

Meet our patient

- 64-year-old woman with **Type 2 Diabetes**
- Patient has a history of hypertension, hyperlipidemia, and recently diagnosed heart failure
- Patient reports experiencing uncomfortable side effects from metformin

Medication	Dose	Frequency
Empagliflozin	25 mg	Daily
Metformin	1000 mg	BID
Semaglutide 2 mg / 1.5 mL injection	0.25 mg	Weekly
Insulin glargine U-300 insulin 300 unit / mL (1.5 mL) injection	118 Units	Daily at bedtime

- Patient on **metformin therapy with an SGLT2 inhibitor, GLP-1 agonist, and basal insulin** for diabetes management

Patient Labs

Blood Pressure	139 / 72
Hemoglobin A1C Normal range < 5.7% Goal range < 7.0%	**8.4 %**
Total Cholesterol (mg/dL) Normal range 150-199 Goal range < 150	95
HDL (mg/dL) Normal range >= 40	**23**
LDL (mg/dL) Normal range <= 30	**29**
Triglycerides (mg/dL) Normal range < 250	**197**
Serum creatinine	**0.77**

Optimal ASCVD risk:

3.6%

SGLT2 Inhibitors and Heart Failure

SGLT2 inhibitors promote **renal excretion of glucose,** which also promotes **diuresis.**

This is the primary mechanism of benefit in heart failure patients, as these medications have a secondary effect of **treating fluid overload.**

Zinman B, Wanner C, Lachin JM et al. Empagliflozin, cardiovascular outcomes, and mortality in type 2 diabetes. *N Engl J Med* 2015;373:2117-2128. doi: 10.1056/NEJMoa1504720. Accessed July 23, 2021.

How can a pharmacist help?

Disease State Monitoring

- Blood pressure
- Blood glucose trends
- Counseling on lifestyle modifications
- Medication therapy optimization

Which of these can a pharmacist manage in a community setting?

American Diabetes Association. Pharmacologic approaches to glycemic treatment: Standards of medical care in diabetes – 2021. Diabetes Care 2021 Jan; 44(Supplement 1: S111-S124. https://doi.org/10.2337/dc21-S009 Accessed July 23, 2021

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Pharmacy Point-of-Care Testing (POCT)

- Accessible, CLIA-waived testing
  - Glucose monitoring
  - A1C testing
  - Cholesterol and lipid testing
- Blood pressure screening

Medication Therapy Management (MTM)

- Diabetes and cardiovascular disease are **complex, chronic conditions** often **managed together**

- MTM is a form of **preventive care** designed to **identify potential drug interactions and necessary therapy modifications** before issues arise

Conducting MTMs: A Primer

- Identifying patients
- Starting the conversation
- Knowing what to look for
- Documentation and action plan

Conducting MTMs: Identifying Patients

- Insurance plans, provider lists
- Look for patients on **multiple medications for chronic conditions**
- Consider addressing potential **adherence issues**
- Allow the patient to **take ownership over their own care**

Conducting MTMs: Starting the Conversation

- Can be in-person, virtual, or over the phone
- Explain the purpose of the visit in patient-friendly terms
- **Allow the patient space to ask questions and express concerns**

Conducting MTMs: Following Up

- Prepare a **Medication Action Plan (MAP)**
  - Summarize issues identified and how the patient should respond
  - Ensure patient understands **when to contact their primary care provider**

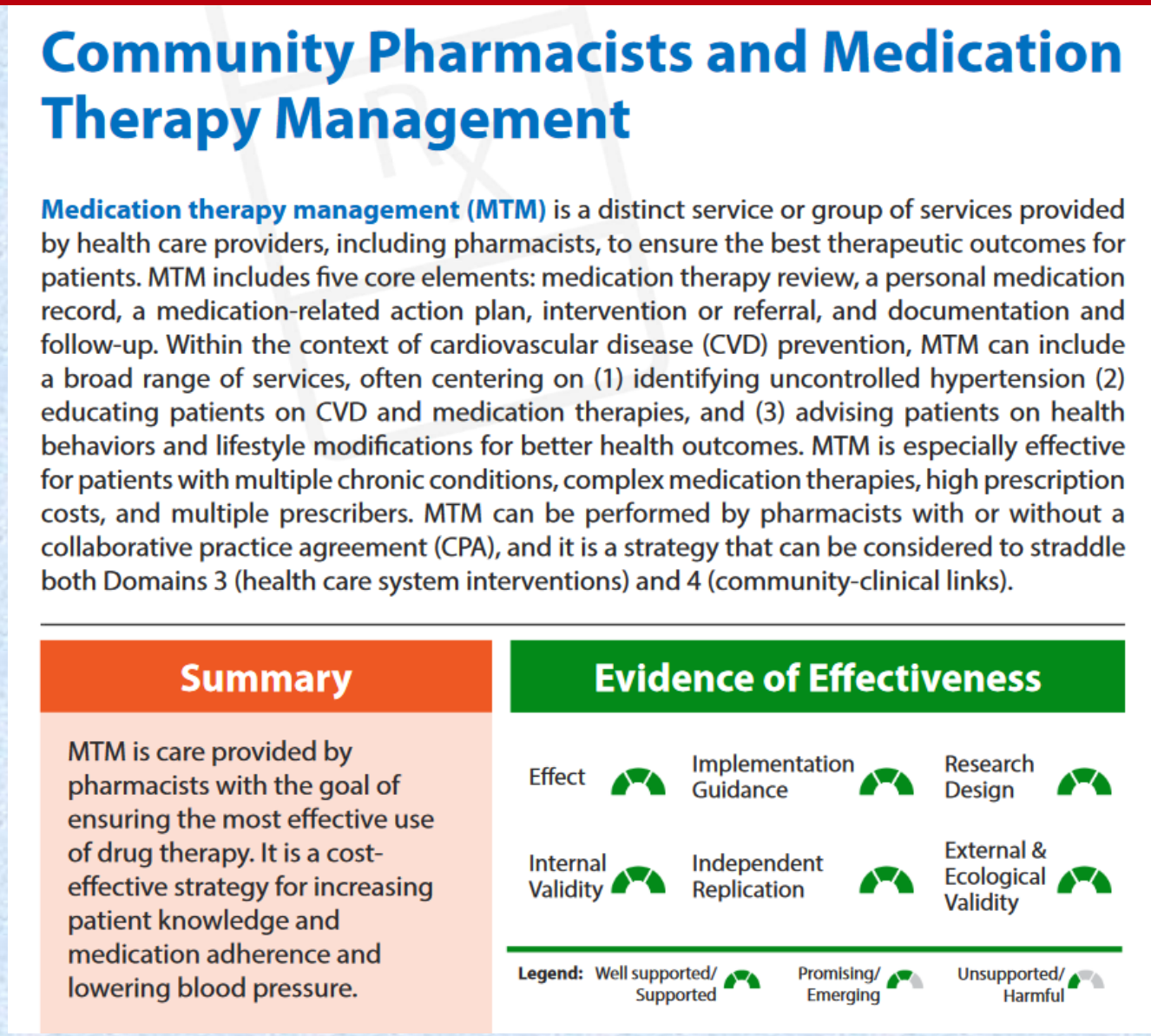
Revisiting our Patient

- Are her medications **working for her?**
  - We can assess blood pressure control and A1C
    - Is patient meeting her goals? Does she need additional therapy or dose adjustments?
  - We can address any adverse effects she may be experiencing, thus improving **adherence**
    - e.g., is the patient taking metformin with meals to lessen the severity of its side effects?

Getting Started: MTM Resources

- CDC Strategy Guide
  - Outlines best practices

https://www.cdc.gov/dhdsp/pubs/guides/best-practices/pharmacist-mtm.htm



Community Pharmacists and Medication Therapy Management

Medication therapy management (MTM) is a distinct service or group of services provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients. MTM includes five core elements: medication therapy review, a personal medication record, a medication-related action plan, intervention or referral, and documentation and follow-up. Within the context of cardiovascular disease (CVD) prevention, MTM can include a broad range of services, often centering on (1) identifying uncontrolled hypertension (2) educating patients on CVD and medication therapies, and (3) advising patients on health behaviors and lifestyle modifications for better health outcomes. MTM is especially effective for patients with multiple chronic conditions, complex medication therapies, high prescription costs, and multiple prescribers. MTM can be performed by pharmacists with or without a collaborative practice agreement (CPA), and it is a strategy that can be considered to straddle both Domains 3 (health care system interventions) and 4 (community-clinical links).

Summary

MTM is care provided by pharmacists with the goal of ensuring the most effective use of drug therapy. It is a cost-effective strategy for increasing patient knowledge and medication adherence and lowering blood pressure.

Evidence of Effectiveness

Effect | Implementation Guidance | Research Design

Internal Validity | Independent Replication | External & Ecological Validity

Legend: Well supported/ Supported | Promising/ Emerging | Unsupported/ Harmful

Summary

- Managing the treatment of patients with diabetes is **complex** and often involves knowledge of multiple disease states.
- SGLT2 inhibitors are an example of how the treatment of two common disease states can be connected.
- Pharmacists have a unique opportunity to combine **clinical knowledge** with **accessible care.**

Take It to Heart: SGLT2 Inhibitors and Cardiovascular Outcomes in Diabetes

Thank you!

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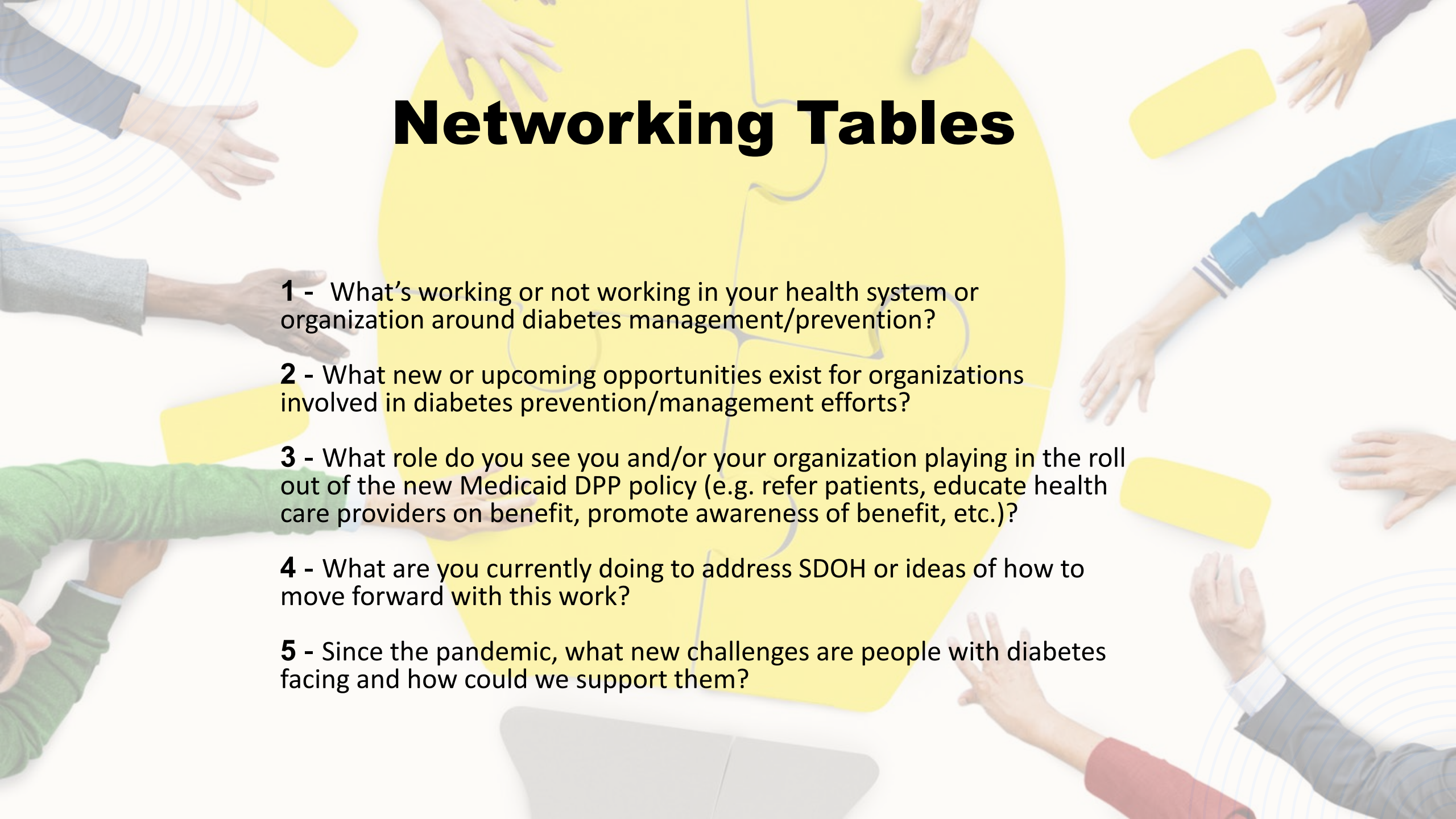

Networking Tables

1 - What's working or not working in your health system or organization around diabetes management/prevention?

2 - What new or upcoming opportunities exist for organizations involved in diabetes prevention/management efforts?

3 - What role do you see you and/or your organization playing in the roll out of the new Medicaid DPP policy (e.g. refer patients, educate health care providers on benefit, promote awareness of benefit, etc.)?

4 - What are you currently doing to address SDOH or ideas of how to move forward with this work?

5 - Since the pandemic, what new challenges are people with diabetes facing and how could we support them?

EVALUATION

Please stop at the table in the hall to complete the sign out sheet for people requesting CEUs.

Evaluation must be completed by Friday, November 11, 2022, to earn CEUs.

CEU certificates will be emailed following the completion of the evaluation.

LOOK FORWARD TO SEEING YOU NEXT YEAR

Thank you and safe travels