Caring for Patients with Complex Chronic Disease: *Key Components and Updates to Diabetes and CKD Management*

Tuesday, September 12, 2023

Course Directors
X. Shirley Chen, MD, MS
Arshad Rahim, MD, MBA, FACP

Provided by
Mount Sinai Health Partners (MSHP) and the
Icahn School of Medicine at Mount Sinai

Mount Sinai Health Partners

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Course Director • Planning Committee	
No Relevant Financial Relationship to Disclose	
Lisa Bloch, MS **Saralynne Brown, MHA** **Alexandra Ingber, MPH** **Arshad Rahim, MD, MBA, FACP**	

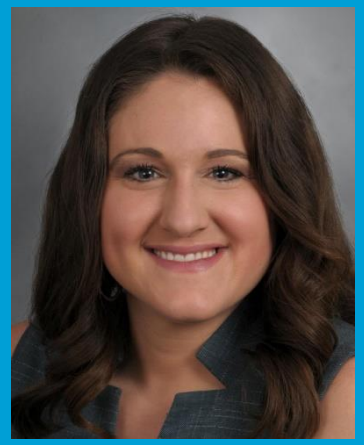
Faculty Speakers (Case Presenters/Panelists):	
No Relevant Financial Relationship to Disclose	**Relevant Financial Relationship to Disclose**
Shirley Chen, MD, MS **Roy Cohen, MD** **Yasmin Khan, MD** **Jenna Palladino, PsyD**	**Joseph A. Vassalotti, MD:** Consultant/Advisor: Renalytix, plc

Welcome and Introductions

Shirley Chen, MD, MS

Roy Cohen, MD

Yasmin Khan, MD



Jenna Palladino, PsyD

Arshad Rahim, MD, MBA, FACP

Joseph A. Vassalotti, MD

Case Presentation

Dr. Roy Cohen

Director of Population Health,
Mount Sinai Department of Medicine

Patient Information

Demographic Information and Background	• 57-year-old Hispanic male • Delayed seeing PCP for almost 2 years largely due to COVID-19 pandemic • Presenting for a 3-month PCP follow-up visit after re-establishing care in March 2022
Medical History	• Type 2 diabetes, diagnosed 10 years ago • Hypertension • CKD stage 3a
Past Surgical History	• None
Medication List	• Lisinopril 20 mg QD • Atorvastatin 40 mg QD • Metformin 1000 mg BID

Continues on next slide …

Patient Information (continued)

Allergies	• Penicillin (rash)
Family History	• Father – diabetes, high cholesterol • Mother – hypertension, anxiety • Brother – diabetes
Social History	• Stable housing – lives with his wife. He has 2 adult children. • Occupation – Uber driver • Former smoker – quit at age 40, 10 pack year history • Alcohol – reports 3-4 drinks per week

June 2022 Visit – Vitals and Labs

Blood pressure	140/90
Last BP reading	*March 2022: 140/85*
Pulse	76
SpO2	98%
Respiratory Rate	12
BMI	**36 (!)**
Total Cholesterol	198 ml/dl
Triglycerides	97 mg/dl
HDL	45 mg/dl
LDL	**103 mg/dl (!)**
Creatinine eGFR	**1.45 mg/dl, 48 ml/min/1.73m^2 *(!)***
10 year ASCVD Risk[1]	11%
A1C trend	***March 2020: 7.2% (!)*** **March 2022: 8.5% (!)**
Last Urine microalbumin creatinine ratio	***March 2020: 120 mg/g Cr (!)***

ASCVD Risk Calculator can be found at:

1. https://tools.acc.org/ascvd-risk-estimator-plus/#!/calculate/estimate/, 2. App Store 3. Epic Dot Phrase: .ASCVD

June 2022 Visit - Physical Exam

General	Well appearing, comfortable, obese
HEENT	The sclerae are anicteric. Jugular venous pressure was normal. Thyroid not enlarged. No lymphadenopathy.
Cardiovascular	Heart sounds were regular, with normal S1 and S2, and no murmurs.
Respiratory	Lungs clear to auscultation bilaterally
Abdomen	Soft, non-tender, non-distended
Extremities	Foot exam – monofilament testing normal, no ulcers or skin breakdown Leg exam – warm and well perfused, with no edema
Skin	No rash or other skin abnormalities
Musculoskeletal	No joint swelling
Neuro	Alert and oriented x 3, speech and affect normal. No focal findings.

PCP Assessment

- Patient reports taking medications as prescribed. He admits to inconsistent physical activity, difficulty losing/maintaining weight and increased anxiety within the past 6 months due to financial stressors.

- PCP orders new labs which show the patient's A1C has increased from **8.5% to 8.9% from March to June 2022.**

Poll Question #1 – *Initial Assessment*

- What is the recommended A1C goal for this patient?

  a) <6.5%
  b) <7.0%
  c) <8.0%
  d) <9.0%
  e) Any of these options would be appropriate

Timeframe: June 2022 Visit

PCP Assessment (continued)

- PCP establishes A1C goal for this patient is <7%

HgbA1c **<6.5%** for select patients	**HgbA1c <7% is the general target for adults**	HgbA1c **<8%** for select patients
May be used selectively for patients at lower risk of hypoglycemia or other adverse effects of more intensive treatment	This threshold has been proven to reduce development of microvascular complications (retinopathy, neuropathy and CKD) and, to a lesser extent, macrovascular complication (non-fatal MI, stroke, CV death) in Type 1 and Type 2 DM. Corresponds to pre-prandial plasma glucoses between 80-130 mg/dl and postprandial (1-2 hrs.) plasma glucose <180 mg/dl.	Patients at increased risk of severe hypoglycemia, limited life expectancy, well established complications, or other compelling reasons for less stringent control

Poll Question #2: *Diet, Exercise and Lifestyle*

PCP orders labs and sees A1C has increased from **8.5% to 8.9%.** The patient reports no structured exercise routine but has tried to increase his daily walking which remains variable.

- What specific physical activity and weight management goals can be recommended when discussing an exercise program with the patient?

a) Weight loss of ≥1% within 6-12 months with 75 minutes/week of weight training
b) Weight loss of ≥3% within 6-12 months with 100 minutes/week of exercise
c) Weight loss of ≥5% within 6-12 months with 150 minutes/week of exercise, and no more than 75 minutes of weight training towards 150 minute weekly exercise target
d) Revisit current goals with patient and collaboratively develop new goals
e) All of the above

Timeframe: June 2022 Visit

PCP Assessment - *Diet, Exercise and Lifestyle*

PCP initiates diet, exercise and lifestyle plans

- Lifestyle interventions should be the first line of treatment for all patients with T2DM.
- Nutrition, physical activity, and behavioral therapy are recommended.

Weight Loss

Weight loss of **≥5%** within 6-12 months.

Diet

Reduction of **500-1000 calories per day** to achieve 1-2 lb/week weight loss

Exercise

Moderate-intensity exercise (such as brisk walking) for ≥150 minutes per week

Exercise goal of 700 calorie/week expenditure

≥3 sessions/week, Min of 10 mins/session

Max 75 min/week of weight training towards 150 minute weekly target

Prescribing an Exercise Plan

- Ask about and document physical activity as a vital sign at each visit
- Two clinically validated questions to assess aerobic activity (from the American College of Sports Medicine "Exercise is Medicine" initiative)
  1. On average, how many days per week do you engage in moderate to strenuous exercise? _____ days
  2. On average, how many minutes do you engage in exercise at this level? _____ minutes

Ideas for Increasing Daily Physical Activity

Do you take Public Transportation?
Try walking to a further stop before you get on or get off 1 stop early.

Always busy at work?
Have a walking meeting with a colleague, get your coffee at a shop that is a little farther, go for a walk on your lunch break

Find yourself not moving a lot while at work, home, or shopping?
Take the stairs instead of the elevator/escalator. If you must take the elevator, get off at a floor or two below and take the stairs the rest of the way up!

Looking to make plans with family or friends?
Make it an active social time – choose walking through a museum, bowling, or mini golf.

Need ways be active in your free time?
Garden, volunteer, or take on a home improvement project rather than using social media, online shopping, or watching TV

Talking Points for Increasing Planned Exercise

Not a fan of gyms or never been an athlete?
Walking is a great place to start. Start slow and build up to 30 minutes or more per day of brisk walking. Recording steps or time spent walking with a paper diary, pedometer, smart watch or activity tracker can help you track your progress.

What if the weather is bad or no access to an exercise facility?
Try an at home exercise like yoga, cardio-dance, or circuit training. Many videos are available online for free without the need for any additional equipment.

No time or feeling too tired to exercise?
Every minute counts! A little exercise is better than none. If you're unable to get 30 minutes one day, try adding a few minutes of dancing to your favorite song, playing tag with kids, or marching/jogging in place during commercials. All of these can help to improve your health and boost your energy.

Prefer to exercise with others?
Join a softball, ultimate Frisbee, or tennis league, find an accountability buddy like a family member or friend, create a walking group at work or home, or sign up for an exercise class at your local community center, workplace, or place of worship.

Adapted from AHA: **Physical Activity as a Critical Component of First-Line Treatment for Elevated Blood Pressure or Cholesterol: Who, What, and How?: A Scientific Statement From the American Heart Association**
https://www.ahajournals.org/doi/full/10.1161/HYP.0000000000000196#d1e1221

Motivational Interviewing

- "A collaborative conversation style for strengthening a person's own motivation and commitment to change."

(Millller and Rollnick, 2013, p.12)

PCP Assessment - *Diet, Exercise and Lifestyle (continued)*

PCP counsels patient on the benefits of:

- **Regular physical activity** for improved blood sugar control, cardiovascular health, weight loss, and stress management.
- The patient is motivated to use an activity tracking device and to start a regular walking plan to walk twice a day for 15 minutes with a goal of walking at least 30 minutes everyday.

PCP engages Certified Diabetes Educators (CDEs) (Diabetes Alliance at MSHS)

- **Develop a detailed plan** geared towards weight loss.
- CDE/RD works directly with the patient to develop a low carbohydrate meal plan to decrease daily intake by 500 calories.

Mount Sinai Health System Diabetes Alliance patient brochure provides more details about the program here:
https://www.mountsinai.org/files/MSHealth/Assets/HS/Wellness/MSHS-Diabetes-Alliance-Brochure.pdf

Poll Question #3: *Pharmacologic Treatment (Endocrinologist Input)*

Case Study Updates

A BMP and urine microalbumin/creatinine ratio are also obtained. Serum potassium is 4.6 and creatinine is stable at 1.5 mg/dl with eGFR 48, but his urine microalbumin/creatinine ratio has increased from 120 to 200 mg/g creatinine. BP is 140/90.

- Based on labs and vitals, what initial pharmacologic steps should be taken?

a) Increase lisinopril from 20 to 40mg
b) Initiate SGLT2i
c) Initiate GLP-1 RA
d) A & B
e) All of the above

Timeframe: June 2022 Visit

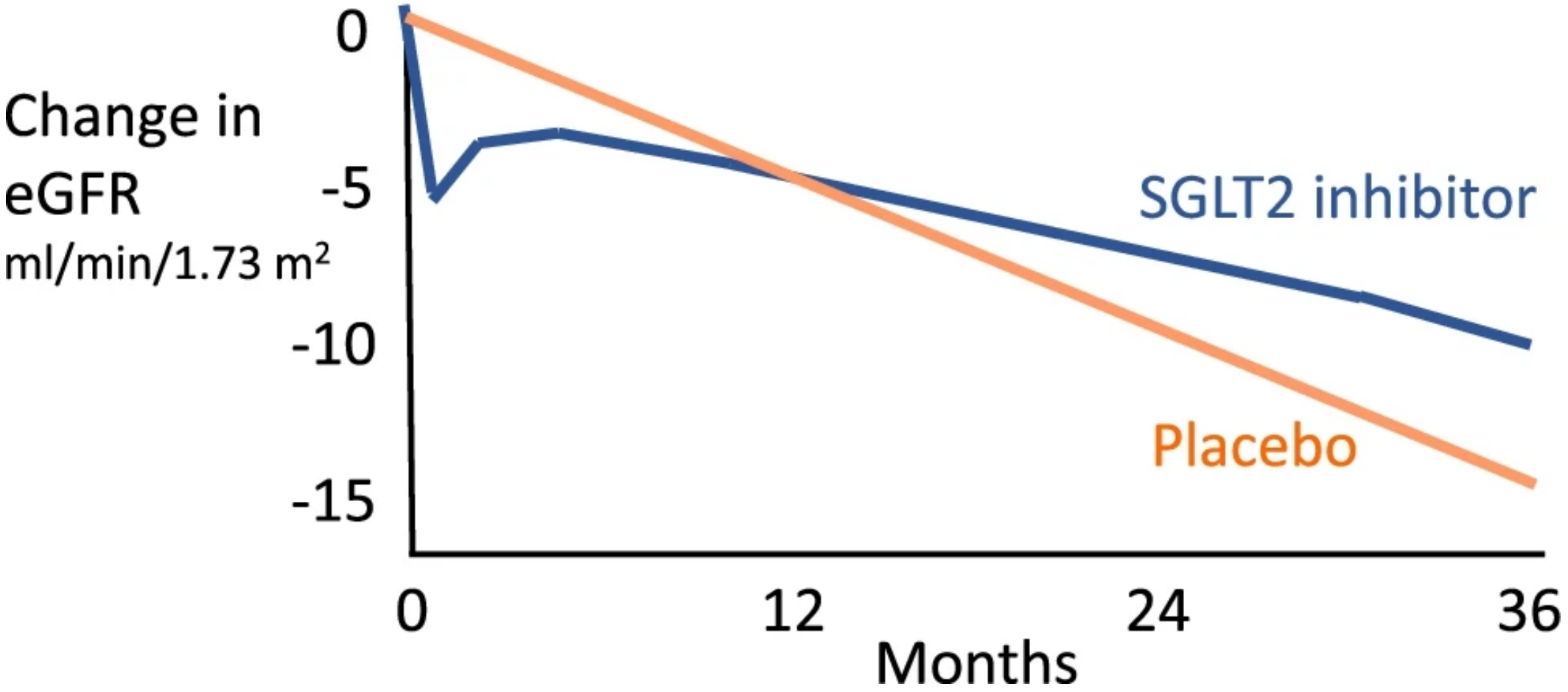
PCP Assessment – *Pharmacologic Treatment*

- PCP increases lisinopril to 40mg. Two weeks later, after a BP check and repeating BMP, the patient is also started on **Empagliflozin 10mg**

Medication Class	Compound & Common Trade Names	Dosages	Starting Dose	Renal Dose Adjustment
SGLT2 inhibitors	Ertugliflozin *Steglatro*	5 mg, 15 mg	5 mg	Recommended for patients with eGFR <45
	Dapagliflozin *Farxiga*	5 mg, 10 mg	5 mg	Recommended for patients with eGFR <30
	Empagliflozin *Jardiance*	10 mg, 25 mg	10 mg	
	Canagliflozin *Invokana*	100 mg, 300 mg	100 mg	

- SGLT2i is recommended for patients with diabetes and CKD with **eGFR ≥20** mL/min/1.73 m2 regardless of albuminuria though UACR ≥200 mg/g is a high priority for initiation
- SGLT2i can be continued until initiation of dialysis or transplant

Expect Hemodynamic Loss of eGFR in the First 4 Weeks After Starting an SGLT-2 Inhibitor



Curr Diab Rep 2022;22(1):39-52. Concept slide loosely based on EMPA-REG, CREDENCE and DAPA-CKD trials

Patient Selection and Follow-up for SGLT-2 inhibitor Use in CKD with T2D

Key Guidelines to Initiating SGLT2 Inhibitors for Patients With T2D and CKD:

- Recommended for patients with type 2 diabetes (T2D), CKD, and eGFR ≥20 ml/min per 1.73 m2
  - Contraindications include: diabetic ketoacidosis, foot ulcers
- Acute drop of eGFR is possible but is not a reason to stop the SGLT2
- Hypoglycemia risk exists when taken with insulin or sulfonylurea, but can be mitigated by reducing doses
- Volume depletion risk increases with a history of AKI or current diuretics

Please reference the 2022 Clinical Practice Guideline for Diabetes Management in Chronic Kidney Disease (KDIGO 2022) for full clinical guidelines.

Kidney Disease: Improving Global Outcomes (KDIGO) Diabetes Work Group. KDIGO 2022 Clinical Practice Guideline for Diabetes Management in Chronic Kidney Disease. Kidney Int 2022;102(5S):S1–S127.

Poll Question #4: *Behavioral Health*

Case Study Updates

Patient reports feeling overwhelming stress and difficulty managing anxiety. He expresses ongoing restlessness, constant worrying, feeling nervous/on edge, difficulty concentrating, and difficulty falling & staying asleep.

- To address behavioral health concerns (i.e. anxiety, stress management), what is the initial step the PCP should take?

a) Refer patient to psychiatrist
b) Assess symptoms in more detail with GAD and PHQ questionnaires
c) Provide additional resources to patient for talk therapy and stress management
d) Consider addition of SSRI
e) A, B, or C

Timeframe: June 2022 Visit

PCP Assessment – *Behavioral Health*

Standard of care for all adults to receive an annual depression and anxiety screening and recommended by the U.S. Preventive Services Task Force (Grade B)

- Common Validated Screening Tools
  - PHQ2/PHQ9
  - GAD2/GAD7

Behavioral Health screeners and resources listed above are available on the Mount Sinai Health Partners Behavioral Health webpage at: https://mshp.mountsinai.org/web/mshp/resources

PCP Assessment – Behavioral Health (continued)

- The patient scores:
  - **14 on GAD-7 and 6 on PHQ-9**
- The PCP and patient mutually agree upon engaging with psychologist for therapy and deferring pharmacologic intervention for now.
- PCP provides patient facing materials and resources for therapy in the after-visit summary

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	(2)	3
2. Not being able to stop or control worrying	0	1	2	(3)
3. Worrying too much about different things	0	1	(2)	3
4. Trouble relaxing	0	1	2	(3)
5. Being so restless that it is hard to sit still	0	(1)	2	3
6. Becoming easily annoyed or irritable	0	1	(2)	3
7. Feeling afraid, as if something awful might happen	0	(1)	2	3

Column totals 0 + 2 + 6 + 6 =

Total score 14

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☑	☐	☐

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? Circle your answer.	Not at all	Several days	More than half the days	Nearly every day
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + 2 + 4 + 0

=Total Score: 6

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people? Circle your answer.

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Follow Up Visit – September 2022 (3 months later)

- Patient returns for follow-up and reports taking his medications and following a structured diet plan.
- PCP orders labs and finds the following:

Labs	June 2022 Visit	September 2022 Visit
Creatinine, eGFR	1.5 mg/dl, 48	1.6 mg/dl, 48
BMI	36	36
Potassium	4.6	4.8
BP	*140/90*	*130/85*
A1C trends	7.2% (March 2020) 8.5% (March 2022) 8.9% (June 2022)	8.2%

Poll Question #5: *Diabetes Management*

Case Study Updates

After following a structured diet plan and adding the SGLT2i, patient's A1C has improved to 8.2%. His weight is unchanged with BMI of 36. The patient expresses persistent anxiety symptoms, difficulty controlling his appetite and frustration with lack of weight loss.

- What should the PCP consider as the next pharmacologic approach for glycemic control?

a) Add prandial insulin
b) Add finerenone
c) Add GLP-1 RA
d) Increase SGLT-2 inhibitor dose
e) Add sulfonylurea

Timeframe: September 2022 Visit

Diabetes Management

- SGLT2 inhibitors can be increased to maximal dose for glycemic control but have not demonstrated increased cardiorenal benefit at higher doses

- Adding a GLP-1 RA will provide greater glycemic benefit for A1c reduction and weight loss. When using in combination with SGLT2i, ensure patient keeps hydrated.

- The MSHP Diabetes Ambulatory Care Pathway, in alignment with ADA, highlights:

  - GLP-1 RA is recommended in most patients with diabetes prior to insulin and can be safely used with SGLT2 inhibitors.

  - For patients with diabetes and at risk or with ASCVD, heart failure or CKD who are unable to take SGLT2 inhibitors, GLP-1 RA are recommended.

The MSHP Diabetes Ambulatory Care Pathway listed above along with additional chronic disease care pathways are available on the Mount Sinai Health Partners Chronic Condition Hub: https://mshp.mountsinai.org/web/mshp/condition-management-hub

GLP-1 RAs

Medication Class	Compounds	Common Trade Names	Dosage strength/ product	Starting dose
GLP-1 RAs	Exenatide	Byetta	5 mcg, 10 mcg pen	5 mcg bid
		Bydureon Bcise (ER)	2 mg powder for suspension or pen	2 mg qweek
	Dulaglutide*	Trulicity	0.75mg, 1.5 mg, 3.0 mg, 4.5 mg injection	0.75 mg qweek
	Semaglutide*	Ozempic	0.25 mg, 0.5 mg, 1 mg, 2 mg injection	0.25 mg qweek
		Rybelsus	3 mg, 7 mg, 14 mg (tablet)	3 mg qday
	Liraglutide*	Victoza	0.6 mg, 1.2mg, 1.8mg injection	0.6 mg qday
GIP and GLP-1 RA	Tirzepatide	Mounjaro	2.5 mg, 5 mg, 7.5 mg, 10 mg, 12.5 mg,15 mg injection	2.5 mg qweek

*GLP-1 RA with proven cardiovascular benefit to date

Role of MRAs in CKD

- MRAs have a role in reducing albuminuria and kidney fibrosis/inflammation

- Use of **steroidal MRAs (spironolactone, eplerenone)** is often limited by risk of hyperkalemia, especially in combination with ACEi/ARB
  - Recommended for patients with comorbid HFrEF
  - Option for patients with uncontrolled hypertension

- **Finerenone** is currently the only **nonsteroidal MRA** with proven clinical kidney and cardiovascular benefits.
  - Shown to reduce kidney failure progression, CHF hospitalizations
  - Recommended for patients with diabetes and CKD with eGFR ≥25 mL/min/1.73 m2 and UACR ≥30
  - Maximize ACEi/ARB therapy → Add SGLT2i if tolerated → Add Finerenone
  - Monitor potassium, start if K <5 and continue if K <5.5

Holistic approach for improving outcomes in patients with diabetes and CKD

Four Major Risk Factors to Assess Every 3-6 Months:

Healthy Diet

Physical Activity

Smoking Cessation

Weight Management

- Medications should be used in combination with addressing lifestyle risk factors
- First and second line medications (SGLT2i, ACEi/ARB, GLP-1 RA, MRAs) have additional renal and cardiac protection benefits
- Management of concurrent conditions, such as Hypertension and ASCVD, is key to improving outcomes
- Risk factors and medication therapy require regular reassessment

Please reference the 2022 Clinical Practice Guideline for Diabetes Management in Chronic Kidney Disease (KDIGO 2022) for full clinical guidelines.

KDIGO Diabetes in CKD Kidney Int 2022;102 (Suppl S5):S1-S127

Poll Question #6 - *Engage Nephrology*

- When should the PCP refer the patient to a nephrologist?

a) Sudden drop in eGFR
b) All Stage 4 CKD (eGFR <30)
c) For complex cases of diabetes with co-existing CKD
d) Hyperkalemia management in CKD
e) All of the above

Thresholds for Referral to Nephrology

- To clarify the cause of CKD and assistance managing related complications
- All Stage 4 CKD (eGFR <30)
- For complex cases of diabetes with co-existing CKD
- Patients with CKD and hyperkalemia limiting recommended therapies (ACEi/ARBs, MRAs)

Referral Indications

GFR Categories (ml/min/1.73m²)				Persistent Albuminuria Categories: A1 Normal-Mildly Increased <30 mg/g	A1 Moderately Increased 30-300 mg/g	A1 Severely Increased >300 mg/g	BMD*	NA Intake**	Diabetes Treatment***		
Stage 1	Normal or High	≥ 90		1 visit/yr if CKD	1 visit/yr	2 visits/yr Refer		<4 g (<2 g/d if HTN or DM)	Metformin	SGLT-2i	GLP-1 RA
Stage 2	Mildly Decreased	60-89		1 if CKD	1	2 Refer					
Stage 3a	Mild-Moderately Decreased	45-59		1	2	3 Refer					
Stage 3b	Moderately-Severely Decreased	30-44		2	3	3 Refer	Assess for Bone Mineral Disorder				
Stage 4	Severely Decreased	15-29		3 Refer	3 Refer	4+ Refer		<3 g (<2 g/d if HTN or DM)			
Stage 5	Kidney Failure	<15		4+ Refer	4+ Refer	4+ Refer					
Hypertension without DM				ACE/ARB, CCB, Diuretic	ACE/ARB Suggested	ACE/ARB					
Hypertension-with DM, GFR>60				ACE, ARB, CCB, Diuretic	ACE/ARB	ACE/ARB					
Hypertension w DM, GFR<60				ACE/ARB							

Risk of progression based on GFR and severity of albuminuria indicated by color (green-very low, yellow-low, orange-moderate, red-high, deep red-very high). Frequency of follow-up based upon GFR and severity of albuminuria (visits per year)

* Bone Mineral Disorder (BMD): Time to initiate monitoring for BMD, based on GFR

** Daily sodium intake based on GFR

*** Appropriate use of SGLT-2, GLP-1 RA, and metformin based on GFR. SGLT-2 preferred. Use GLP-1 RA if SGLT-2 not tolerated or GFR <30

**** Recommended hypertension treatment based on severity of microalbuminuria and presence/absence of DM. Use highest tolerated dose.

Poll Question #7 - *Endocrinology/ Continuous Glucose Monitoring*

Case Study Updates Patient A1C remains above goal at **8.2%.** The patient and PCP agree to start semaglutide (Ozempic), a GLP-1 RA. He is motivated to work on his diet and wants to better understand what is driving his high blood sugars.

- What next step should the PCP consider?

a) Addition of basal insulin
b) Consider recommending Keto diet
c) Consider continuous glucose monitoring
d) Consider fasting and post-prandial blood glucose checks
e) C or D

Timeframe: September 2022 Visit

Glucose Monitoring Options

- Fasting and post-prandial blood glucose checks can be valuable
- Encourage testing in the middle of the day when fasting blood glucose appears to be at goal
- Engage Diabetes educator for teaching and follow-up
- Patients who may be candidates for Continuous Glucose Monitoring*:
  - Taking medications that cause hypoglycemia with hypoglycemia unawareness
  - Treated with insulin therapy
    - **Medicare/Medicaid:** CGM services are now covered for all patients with diabetes who are treated with insulin **or** who have a documented history of problematic hypoglycemia
  - Having frequent and/or nocturnal hypoglycemia or other excessive glucose variability
  - Whose activity is variable/intense
  - Willing and able to use CGM on a nearly daily basis and receive ongoing device education
  - Unable to obtain glycemic goals
  - **Considerations:** *Insurance coverage and cost to patient*

* https://diabetesjournals.org/clinical/pages/continuous_glucose_monitoring

Poll Question #8 - *Endocrinology*

- When should the PCP refer to endocrinology?

a) Patients with A1c > 9, despite adherence to therapy
b) Recurrent hypoglycemia
c) Continuous subcutaneous insulin infusion (insulin pump) therapy
d) All of the above

Referral Criteria for Endocrinology

- Patients with A1c > 9, despite 6 months of adherent therapy
- Recurrent hypoglycemia
- Continuous subcutaneous insulin infusion therapy (insulin pump)

Poll Question #9 – *Behavioral Health*

Case Study Updates Patient has started cognitive behavioral therapy every 2 weeks but expresses limited improvement in his anxiety symptoms.

- What steps should the PCP take in management of his GAD?

a) Discuss increasing frequency of therapy session to weekly
b) Discussion of pharmacotherapy with initiation of SSRI medication
c) Prescribe benzodiazepine
d) A & B

Timeframe: September 2022 Visit

SSRI Recommendations

SSRIs are first line medications for both anxiety and depression

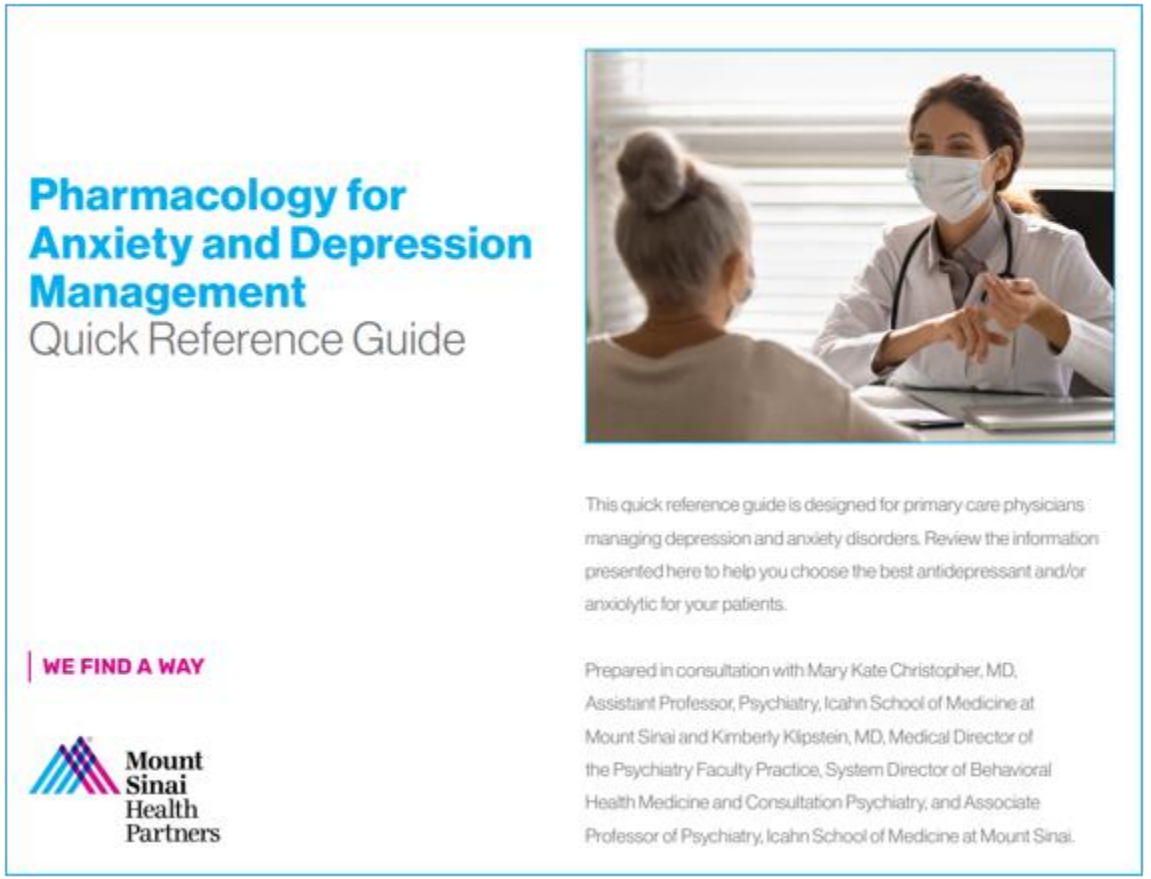
- SSRIs have a black box warning due to the increased the risk of suicidal thoughts and behaviors in pediatric and young adult patients in short-term studies. Closely monitor for clinical worsening and emergence of suicidal thoughts and behaviors.

- Start at low dose and increase every 2-4 weeks as appropriate. An adequate trial requires at least 4-8 weeks on an effective dose.

Educate patients about known side effects of SSRIs:

- **Advise patients not to stop taking SSRIs abruptly, as these need to be gradually tapered prior to stopping.**

- **Encourage patients to raise any medication concerns.**



Find SSRI recommendations in the MSHP Pharmacology for Anxiety and Depression Management Quick Reference Guide

Pharmacology resources for behavioral health treatment are available on the Mount Sinai Health Partners Behavioral Health webpage at: https://mshp.mountsinai.org/web/mshp/resources

Behavioral Health- Anxiety Management

- After discussion with the patient, PCP starts fluoxetine 10mg daily while patients attends more frequent therapy sessions
- Other non-pharmacologic ways to manage his symptoms are also discussed including:
  - Maintaining regular exercise and avoiding inactivity
  - Eating healthy options and limiting alcohol or other substance use
  - Focus on positive sleep habits
  - Build a structure and routine
  - Stay connected with family and friends
  - Limiting time of social media and news outlets
  - Meditation, deep breathing, or a brief yoga practice
  - Designate time to have fun

Behavioral Health Resources for Patients

Databases to find treatment and support for your behavioral health needs:

- For residents of **NYC:**
  - **NYC Well** – https://nycwell.cityofnewyork.us/en/
- For residents **outside NYC:**
  - **Find Treatment** – https://findtreatment.gov/
- Information about treatment providers in private or group practice who may accept a variety of commercial insurances:
  - **SOL Mental Health** – https://solmentalhealth.com/
  - **Valera Health** – https://www.valerahealth.com/
  - **Headway** – https://headway.co/
- If you are thinking about harming yourself or others, experiencing a psychiatric emergency, or need immediate support, call or text 988 or go to the nearest emergency room.
- You can also chat with 988 at https://988lifeline.org/chat/."

For MSHS providers: Behavioral Health Referral Information SmartText/ AVS SmartPhrase coming soon!

Patient Update – March 2023 (6 months later)

- Patient has been successful in maintaining 5% weight loss
- Patient remains engaged with RD for diet plan
- Continues regular physical activity 30 minutes walking daily
- Reports talk therapy as beneficial and continues therapy
- Fluoxetine has been beneficial but he feels ready to begin tapering off SSRI

Medication List

• Lisinopril 40 mg QD
• Atorvastatin 40 mg QD
• Metformin 1000 mg BID
• Empagliflozin 10mg QD
• Semaglutide 1 mg qweek
• Fluoxetine 20 mg QD

Diabetes and CKD Management Resources

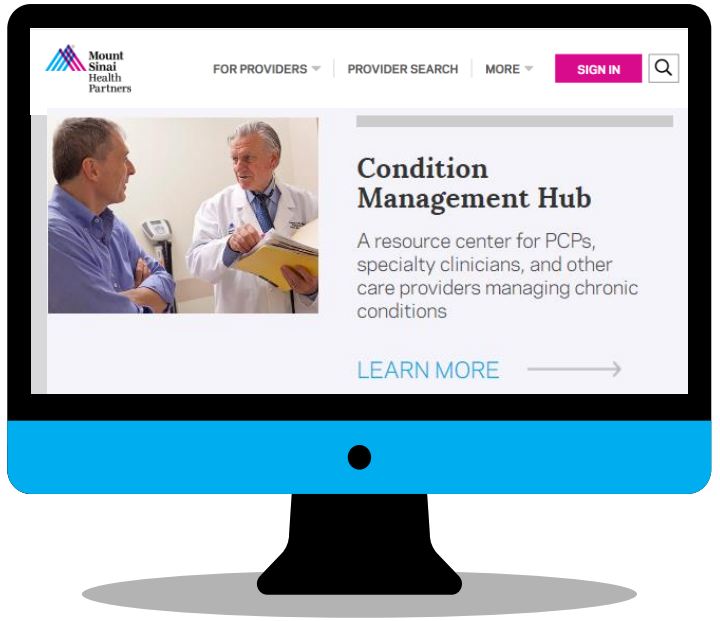
- **Ambulatory Care Pathways for CKD and Diabetes**

  Visit the Chronic Condition Management Hub:
  https://mshp.mountsinai.org/web/mshp/condition- management-hub

- **Chronic Condition Tip of the Month,** check your inbox!

- **Behavioral health resources** on the MSHP Behavioral Health Hub:
  https://mshp.mountsinai.org/web/mshp/behavioral-health

- **Online Provider Search tool** to find referrals for your patients within Mount Sinai Health Partners Clinically Integrated Network



Visit us online
https://mshp.mountsinai.org/web/mshp/home

THANK YOU

Mind Matters ECHO

Inside 988

A Conversation with SAMHSA Leaders

Thursday, September 21

5:30—7:00pm

Live via Zoom | CME-accredited

Moderated by

Anitha Iyer, PhD
Course Director
Director, Behavioral Health
Population Management
Mount Sinai Health Partners

Visit bit.ly/mindmatters-sept23 to register

James Wright, LPC

Division Director, Crisis Operations
988 and Behavioral Health Crisis
Coordinating Office
Office of the Assistant Secretary, SAMHSA

Robyn Filler, LCSW

Director- Clinical Best Practices & Standards
988 Suicide and Crisis Lifeline
Vibrant Emotional Health

Eva Korolishin

Senior Manager for 988 Center Engagement
Vibrant Emotional Health