Sweet Success
California Diabetes and Pregnancy Program

Sweet Success: Diabetes and Pregnancy Newsletter From CDAPP Regional Programs

2012

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Budget Cuts Reduce CDAPP Regional Program Services

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Progressive cuts over the last several years to the State's allocation of Title V Federal Funds that support Maternal Child Health services have impacted our California Diabetes and Pregnancy Program (CDAPP) referred to as "CDAPP Sweet Success." As announced on July 7th, 2011 for the fiscal year, 7/01/2011 - 6/30/2012, the funding for 10 Regional CDAPP Sweet Success Programs that recruit, train and provide consultation to local CDAPP Sweet Success Affiliates was reduced 50% and it was proposed that the Regional CDAPP Sweet Success Programs will end June 30, 2012.

In order to meet CDAPP Sweet Success Affiliate needs, we are developing a new CDAPP Sweet Success Resource and Training Center to continue to support our CDAPP Sweet Success Affiliates.

Please note that these changes in no way affect CDAPP Sweet Success Affiliate's reimbursement for the services they provide.

Your regional CDAPP Sweet Success Representatives will continue to provide consultation and education to you, their CDAPP Sweet Success Affiliates, but at a reduced level of intensity until June 30, 2012. You may find that your CDAPP Sweet Success Program Representatives have to do more through e-mail and teleconferences and less through face-to-face interaction.

Statewide Data collection to illustrate quality improvement and regional and state trends has continued. CDAPP data for 2010 that affiliates sent to the CDAPP Data Center was processed and made available to regional CDAPP staff to share with affiliates and posted to the CDAPP Website earlier this year. The raw (unprocessed) data for 2011 has been consolidated and returned to Regional CDAPP Sweet Success Staff to share with CDAPP Sweet Success Affiliates. Over 21,000 women were served in 2011 by CDAPP Sweet Success Affiliates as reported to your Regional CDAPP Sweet Success Program Staff.

We encourage affiliates to continue to collect data at their site to illustrate their individual quality improvement, document services provided and reflect staffing needs. A sample "CDAPP Sweet Success Individual Affiliate Data Form" (Suggested Format) is included in the newsletter for your consideration.

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Postpartum Depression in Sweet Success Moms: Providing Support

Kay Goldstein, MFT, Behavior Medicine Specialist, Regions 1 and 3

Postpartum depression continues to have a major impact on the mothers, infants and partners who are affected by it. Incidence rates are high and seem to be on the rise. Study findings are reporting rates as low as 13%(1) and as high as 28%.(2)

"A phone call that may appear to you as impersonal support from a stranger can appear as an appropriate level of intervention to a depressed mom..."

In February 2009, JAMA published a study that collected data from 11,000 women on MediCaid in New Jersey. Those who had diabetes complicating their pregnancies had almost twice the rate of PPD (15.2%) compared to those moms without diabetes (8.5%). This breakthrough research corroborated what mental health providers in Sweet Success have known for a long time: the women we serve have more stress, more anxiety and more PPD than women who do not have diabetes complicating their pregnancies. This research, which included perinatal as well as postpartum data, concluded that gestational diabetes was "independently associated with perinatal depression, including new onset of postpartum depression..."(3)

This range of incidence means that in your patient population, either one in ten, or up to one in four, moms are struggling with issues of depression.

The JAMA study and the studies that find higher rates of depression are also notably researching women who have lower incomes or are considered to be in poverty. Many of our patients find themselves in this situation and are also at increased risk because of their economic circumstances.

These findings are one of the many reasons why we encourage and emphasize the importance of screening for depression. And along with screening, we need to provide services and resources to those moms who need them.

For those providers who have had budget cuts, do not have enough staff to cover all patient needs, or are in rural areas with fewer referral resources, there are still options for providing services and support. Research shows that besides a referral to a social worker, there are a number of things that can be offered to a patient with "mild" to "moderate" depression. These include:

- Empathy and support
- Telephone support from you and the staff
- Telephone support from hotlines and warmlines
- A handout with information about depression
- Home visits from an RN or health worker
- Increased visits from friends and family
- More partner support
- Help with childcare
- More sleep

Empathy and listening to your patient during her appointment with you can provide an important level of support. Follow-up phone calls from you, including your empathy and listening skills, can add to that support.

Even if you do have access to counseling referrals, some moms will be reluctant to go to a mental health support person because of stigma and embarrassment.(4) If you think your patient needs more support than you and your program can offer her, and she is reluctant to go into counseling or cannot afford it, you can offer phone call support. If you and your staff do not have time, you can give her a list of hotlines and warmlines. A phone call that may appear to you as impersonal support from a stranger can appear as an appropriate level of intervention to a depressed mom. She does not have to leave her house or her children and she is not "making a big deal about it", but rather is discussing her "high stress".

Providing a handout is another way to offer support but in a low-key way. It can be a booklet(5) or, if your population has low literacy, a one-page, large text sheet of paper with information about depression which includes a few websites, some local resources and an emergency phone number. If you don't have time to make up your own handout, you can do some on-line research or go to med-edppd.org where they have easy one-page handouts to educate your patients. (The on-line information sheets often offer ideas that women can implement on their own.)

Encouraging your patient to reach out and break her isolation through contact with family, friends, exercise buddies, church members, etc. can also relieve the pressures of a

Continued on Page 3

rough pregnancy. Help from family and friends with household chores and childcare can relieve some stress. Friends and family can also encourage and participate in visiting and exercising; a walk to and around the mall is a popular form of recreation these days. And of course, the simplest things – like getting more sleep – will improve anyone's mood, especially someone who is struggling with their feelings.

Low-income moms have higher rates of depression and numerous added burdens which complicate their ability to seek, accept, engage in and benefit from psychosocial treatment.(6) These patients sometimes think their symptoms are mild, when in fact they are not. They are found to be very worried about taking antidepressants and often feel stigmatized about a referral to mental health services.

Here are some other specific ways you can help these moms during their appointments with you:

1. If possible, locate your mental health care support (LCSW) within your perinatal care program. This normalizes the offer of support.

2. Minimize clinical terms. Use informal terms that moms might use. Instead of "depression" or "anxiety", use words like "stress". Ask questions like "How have you been holding up lately?" rather than "Are you depressed?"

3. Engage them in their own mental health treatment with self-care ideas. Ask them what makes them feel more engaged and involved.

4. See if you can organize previous moms in your program to make phone calls to particularly isolated women.

5. If you are offering a psychotherapy referral, offer it as a way to "decrease the stress".

An easy way to remember how you can H.E.L.P. is with this acronym:

H – Highlight the positive

E – Express interest

L – Listen

P – Provide simple and helpful suggestions and support

"Relationship is reparative." If you are being genuinely kind and caring, you are making a difference in how your patient feels. You may not be lifting her depression, but you are breaking her isolation, and that is an important step. Do not underestimate the importance of your empathic presence in these moms' lives.

(1)O'Hara MW, Swain AM, Rates & Risk of PPD, Int Rev Psychiatry 1996;8:37-54

(2)Goyal D, Murphy SO, Cohen J, Immigrant Asian Indian women and postpartum depression, J Ostet Gynecol Neonatal Nurs. 2006 Jan-Feb;35(1):98-104

(3)Kozhimannil KB, Pereira MA, Harlow BL, Association Between Diabetes and Perinatal Depression Among Low-Income Mothers, JAMA 2009; 301(8)842-847

(4)Levy, O'Hara, Psychotherapeutic interventions for depressed, low-income women: A Review of the Literature, Clin Psych Rev (2010)30;934-950

(5)Depression During and After Pregnancy, A Resource for Women, Their Families, and Friends, US Dept. of Health and Human Services, 1-888-Ask-HRSA (provided at no charge in quantities up to 100; in English and Spanish)

(6)Miller L, Treatment Modalities in Peri-Natal Depression; 6/4/2010, Pittsburg Training Module #4; mededppd,org

Diabetes & Pregnancy Study Group-West 2011

Moving the Maternal-Pediatric Paradigm Forward

Suzanne Sparks, RN, BSN, CDE, Region 7

The Diabetes & Pregnancy Study Group-West conference was held this summer and covered very pertinent topics related to maternal factors such as diabetes, obesity, inflammation, & other metabolic components impact fetal growth, and long-term genetic characteristics of the offspring.

The environment in which one is born impacts epigenetics, which is altered gene formation caused by external factors. The intrauterine environment may suppress some gene expression & facilitate others. Maternal obesity, infection, microbes, & chemicals all play a role in influencing offspring's susceptibility to certain diseases. All cells have the same DNA, but different functions.

In fact, fetal origins can program offspring for chronic disease. When birth weight is small or large for gestational age, there is increased risk of type 2 diabetes in the baby. Breastfeeding decreases the risk of "catch up" growth patterns at ages 5-8 years.

Maternal and intrauterine characteristics can metabolically imprint the fetal pancreas for increased insulin resistance in later life. Fetal production of insulin is not essential for fetal growth; yet many fetuses of diabetic women produce insulin when they receive high-glucose blood from the mother via the placenta.

With maternal obesity & GDM, there is increased fetal hepatic lipid storage. Projection is that this will lead to non-hepatic fatty liver disease requiring liver transplantation in the offspring's future.

Both type 1 and type 2 diabetes in mothers pose increased risks to the women and their offspring. Type 1 and type 2 diabetes present markedly increased risks of impaired glucose tolerance in their children at relatively young ages.

Maternal nutrition has marked consequences on the early life of the offspring. Maternal obesity increases fetal risks for stillbirth, miscarriage, intrauterine growth restriction, and preterm labor. Altering maternal diet can change the placental environment. A maternal high-fat diet can increase fetal adiposity, hepatic fat stores, and insulin resistance; it can also cause decreased uterine blood flow.

Changing the diet of pregnant women with diabetes from the traditional GDM carb-restricted diet to a diet of 60% complex carbohydrates, 25% fat, & 15% protein showed increased maternal insulin production at 36 weeks, with no rise in triglycerides.

To optimize maternal & infant outcomes postpartum, it is essential to have insulin protocols in place for labor & delivery if they are needed.

Methods for glucose regulation postpartum include use of NPH insulin to cover basal blood glucose levels; then adding Lispro to cover carbohydrates eaten at meals. It was recommended that insulin should not be administered intravenously.

For women who are lactating, blood glucose values will be lower, and there is increased risk for maternal hypoglycemia. There is evidence for increased incidence of metabolic syndrome when breastfeeding is for a brief period of time. There is a decreased incidence of metabolic syndrome in those who breastfed for longer periods of time. A large Kaiser Permanente study is currently under way, & appears to show that those who formula fed had increased incidence of obesity.

Women who have had GDM need to incorporate three strategies to prevent type 2 diabetes later on. This includes diet, exercise, and breastfeeding. Women who follow these three recommendations have increased likelihood of achieving/maintaining the Institute of Medicine's recommended weight goals.

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The State CDAPP website, http://cdph.ca.gov/CDAPP has been enhanced over the last few years and continues to be a source of information and education. Some highlights include:

- The ***Guidelines for Diagnosis of Hyperglycemia in Pregnancy – 2011***, also known as the ***Hyperglycemia Diagnostic Algorithm*** is available under the heading **Professional Information.**
- The " **California MyPlate for Gestational Diabetes**" has been placed under the heading **New Information.**
- Several brochures and materials that are available from the CDAPP Sweet Success Resource and Training Center are on the CDAPP Sweet Success Website and more will be added in the future.
- CDAPP Data through 2010 has been posted to the website.
- Updates to the "*CDAPP Sweet Success Guidelines for Care*" are nearing completion. Once completed and approved, they will be posted on the CDAPP Sweet Success Website and printed copies will be made available through the CDAPP Sweet Success Resource and Training Center.

The Memorandum of Understanding (MOU) that CDAPP Sweet Success Affiliate sites have with their Regional CDAPP Sweet Success Program remains active until 6/30/2012.

Beginning July 1, 2012, a new MOU between each CDAPP Sweet Success Affiliate and the CDAPP Sweet Success Resource and Training Center will go into effect, and all services for CDAPP Sweet Success Affiliates will be provided by the CDAPP Sweet Success Resource and Training Center**. A sample of the new MOU, California Diabetes & Pregnancy Program, CDAPP Sweet Success Memorandum of Understanding, is contained in the newsletter.**

A sample of a new **CDAPP Sweet Success Affiliate On-Line Annual Survey Form is also included in the newsletter for your reference.** This survey form will reflect 2012 annual data to be submitted to the CDAPP Sweet Success Resource and Training Center by **the end of February 2013**.

To celebrate and honor the contribution and accomplishments of the Regional CDAPP Sweet Success Programs staff, we will have a celebration in Sacramento on June 22, 2012.

As we transition through these challenging times we appreciate the dedicated and important services that have benefitted pregnant women with diabetes provided by the Regional CDAPP Sweet Success Staff and CDAPP Sweet Success Affiliates.

We encourage you to share your thoughts and ideas about future resource needs with your CDAPP Sweet Success Regional Program Representative or directly with the CDAPP Sweet Success Resource and Training Center.

Phone: (858) 536-5090

Website: http://cdappsweetsuccess.com (effective 7/1/12)

All forms referenced in this article are available at the CDAPP Sweet Success website.

Please refer to the last pages of this newsletter for all form samples referenced in this article.

Lilly Updates Humulin R U-500 label to Prevent Errors

Reprinted with permission from Andrew R. Young President Diabetes in Control ***Keeping Clinicians Current***

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This article originally posted August 25, 2011 and appeared in Safety and Error Prevention, Medication, Issue 588

The labeling of HUMULIN R (insulin regular) U-500 was updated recently. The new label includes information about medication errors and their prevention....

Some errors have occurred when healthcare providers have used a U-500 vial instead of a U-100 vial. The U-500 vial contains 20 mL versus 10 mL or 3 mL for U-100 vials. U-500 vials are marked with a band of diagonal brown stripes to distinguish it from the U-100 vial, which has no stripes. "U-500" is also highlighted in red on the label.

To prevent unnecessary errors, the prescribed dose of U-500 should always be expressed in actual units of U-500 along with corresponding markings on the syringe the patient is using (i.e., a U-100 insulin syringe or tuberculin syringe).

Many errors occur due to dosing confusion when U-500 doses are prescribed in units or volume corresponding to a U-100 syringe, or when the prescribed dose is administered without recognizing that the markings on the U-100 syringe do not directly correspond to U-500 doses. If U-100 insulin syringes are used, since their markings are in units and are designed and intended for use with the less concentrated U-100 insulin products, it is extremely important to explain the amount of Humulin R U-500 insulin to be administered in both the actual dose and with specification of "unit markings" on the U-100 syringe.

Instruct the patient to inform hospital or emergency department staff of the actual dose of U-500 prescribed, not the unit markings on the U-100 syringe in the event of a future hospitalization or visit to the emergency department. If tuberculin syringes are used, since their markings are in volume (mL), the actual amount of Humulin R U-500 should be explained in both actual dose and with specification of volume (mL).

Note from the Publisher: A helpful conversion chart is provided in this week's Tool for Your Practice, the Humulin-R 500 New Conversion Chart, and in the new package and should always be used when administering U-500 doses with U-100 insulin syringes or tuberculin syringes.

A change in U-500 labeling clarifies that clinical experience has shown it frequently has time action characteristics reflecting both prandial and basal activity. It takes effect within 30 minutes, has a peak similar to that observed with U-100 regular human insulin. The injection U-500, normally given 2-3 times a day, should be followed by a meal within approximately 30 minutes of administration.

Institute for Safe Medication Practices
www.ismp.org

Lilly Updates Humulin R U-500 label to Prevent Errors

The labeling of HUMULIN R (insulin regular) U-500 was updated recently. The new label includes information about medication errors and their prevention.

(See Table on Page 7 for conversion chart)

For further information visit the Medication Safety and Error Prevention section for more articles and tools found here:
http://www.diabetesincontrol.com/topics/safety-and-error-prevention

Sign up for their newsletter at no cost to keep on top of the latest diabetes care information right here:
http://www.diabetesincontrol.com/subscribe

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Conversion Information for Humulin R U-500 Insulin Dose When Using a U-100 Insulin Syringe or a Tuberculin Syringe

Table 1: Conversion Information for Humulin R U-500 Insulin Dose When Using a U-100 Insulin Syringe or a Tuberculin Syringe Humulin R U-500 dose (units)	U-100 insulin syringe(unit markings)	Tuberculin syringe(volume in mL)
25	5	0.05
50	10	0.1
75	15	0.15
100	20	0.2
125	25	0.25
150	30	0.3
175	35	0.35
200	40	0.4
225	45	0.45
250	50	0.5
275	55	0.55
300	60	0.6
325	65	0.65
350	70	0.7
375	75	0.75
400	80	0.8
425	85	0.85
450	90	0.9
475	95	0.95
500	100	1.0
Dose (actual Humulin R U-500 units)	Divide dose (actual Humulin RU-500 units) by 5	Divide dose (actual Humulin RU-500 units) by 500

For doses other than those listed above refer to the following formulas:

U-100 insulin syringe

Divide prescribed Dose (actual units) by 5 = Unit markings in a U-100 insulin syringe.

Tuberculin syringe

Divide prescribed Dose (actual units) by 500 = Volume (mL) in a tuberculin syringe

Storage

Not in-use (unopened): Humulin R U-500 vials not in-use should be stored in a refrigerator, (2° to 8°C [36° to 46°F]), but not in the freezer.

In-use (opened): The Humulin R U-500 vial currently in-use can be kept unrefrigerated as long as it is kept as cool as possible (below 30°C [86°F]) away from heat and light. In-use vials must be used within 31 days or be discarded, even if they still contain Humulin R U-500.

Do not use Humulin R U-500 after the expiration date stamped on the label or if it has been frozen.

HOW SUPPLIED

Vials, 500 units/mL, 20 mL (HI-500) (1s), NDC 0002-8501-01

Eli Lilly, Literature revised March 2011

www.diabetesincontrol.com

CDAPP SWEET SUCCESS AFFILIATE ON-LINE ANNUAL SURVEY

Please complete and return by email to the CDAPP Sweet Success Resource and Training Center one week prior to your conference call.

use your **TAB** or **ARROW** keys to highlight/go to the next field

Affiliate or Satellite Name:	**Affiliate or Satellite Number:**
Date of Inception as CDAPP Sweet Success Affiliate or Satellite:	
Affiliate or Satellite Lead Staff:	
Affiliate or Satellite Medical Director:	
Affiliate or Satellite Address:	
Email Address:	
Affiliate or Satellite Telephone Number:	**Fax Number:**
Check the best way to contact Lead Staff ☐ phone ☐ email ☐ other	

Lead Staff Name(s)*:	RN or RD license #	Expiration date	Training Name and Date	# of hours	Voice Mail Number &/or Email Address
☐					
☐					

SITE SPECIFIC DATA *This section reflects Annual data (2012)*				
Clients	**Number**	**Diagnosis at first CDAPP Sweet Success visit**		
		# Type 1 Diabetes	**# Type 2 Diabetes**	**# GDM**
New clients				
Continuing clients				
Total number of clients				
How can the CDAPP Sweet Success Resource and Training Center help you?				
Affiliate staff member(s) completing this form:				**Date**
CDAPP Sweet Success Resource and Training Center team member(s) review				**Date**

Revised on 3/2/2012

CDAPP Sweet Success Individual Affiliate Data Form (Suggested Format)

Affiliate_____ Satellite_____ Initials_____

Client ID	Maternal Information Demographic Data								Pre-pregnant	First Antepartum Sweet Success Visit				Diabetes Diagnosis at first Sweet Success visit (select all that apply)								Treatment at First Sweet Success Visit (select all that apply)								Last Sweet Success Visit Before Delivery			Treatment at Last Sweet Success Visit (check all that apply)						Total Number of Sweet Success Visits			
	Hispanic Origin Yes (Y) No (N) Unknown (UK)			Race/Ethnicity •Caucasian (C) •Asian (A) •African American (AA) •Multiracial (M) •Unknown (UK)					weight (lbs)	Estimated delivery date (EED)				•Unknown (UK) •Pre-diabetes prior pregnancy (P) •1 abnormal value only (A) •History of GDM (H) •GDM (G) *Date of Diagnosis _ •Type 1 Diabetes (T1) •Type 2 Diabetes (T2) •Diagnosis with A1C during pregnancy (D)								UK	Diet And Exercise	Diet and Exercise plus medication					Prenatal Edinburgh Score (P)			UK	Diet And Exercise	Diet and Exercise plus medication					Face to Face (F) Phone (P) Fax Email (E)			
																								Oral •Glyburide (G) •Metformin (M) •Other (O) (Specify)			Insulin •MDI •Pump (P)								Oral •Glyburide (G) •Metformin (M) •Other (O) (Specify			Insulin •MDI •Pump(P)					
	Y	N	UK	C	A	AA	M	UK		Date	Ht	Wt	EED	UK	P	A	H	G*	T1	T2	D			G	M	O	MDI	P	Date	Wt	P			G	M	O	MDI	P	F	P	Fax	E

Updated 4-13-12

California Diabetes & Pregnancy Program
CDAPP SWEET SUCCESS
MEMORANDUM OF UNDERSTANDING

This is a Memorandum of Understanding (MOU) between the California Diabetes and Pregnancy Program (CDAPP) Sweet Success Resource and Training Center, and the CDAPP Sweet Success Affiliate Name, number 00.00, effective July 1, 2012

Satellites of this affiliate can have a separate MOU or be listed on page 2 of this agreement.

As a **CDAPP Sweet Success Affiliate, we understand that the expectations are to:**

- Provide patient care by program health care providers who are knowledgeable in the **CDAPP Sweet Success Guidelines for Care** and who incorporate these guidelines into their current practice.
- Ensure that all affiliate staff that provide diabetes care are trained in the care of women with diabetes
- Data collection by affiliates is recommended for validation of services to patients and quality improvement

As a **CDAPP Sweet Success Affiliate** we agree to:

- Participate in an on-line annual site survey conducted by the CDAPP Sweet Success Resource and Training Center staff including the reporting of number of new and existing clients treated annually.
- Participate in annual educational programs for a minimum of 4 hours in CDPH Sweet Success approved courses to keep up to date with current diabetes care practices and information. New affiliates will complete 8 hours of training in CDAPP Sweet Success approved courses.

The **CDAPP Resource and Training Center** will provide:

- Access to materials and supporting documents, **CDAPP Sweet Success Guidelines for Care**, access to CDAPP Sweet Success patient education materials, newsletters, journal articles and related resources at discount rates.
- Access to diabetes and pregnancy educational webinars at discount rates, and on-line annual site survey
- Inclusion in CDAPP Sweet Success Website which lists official affiliate sites by county
- An annual certificate of recognition of affiliate status that can be displayed verifying the site has met requirements to be an **CDAPP Sweet Success Affiliate**

Affiliate Representative: Representative's Name	**Date:** Date Signed
Resource and Training Center Staff: Name	**Date:** Date Signed

CDAPP Coordinators

Region 1 and 3

North Coast and East Bay Region

415.476.9877

Region 2

Northeast Region

916.733.1705

Region 4

Mid-Coastal Region

650.723.5763

Region 5

San Joaquin/Sierra Region

559.244.4546

Region 6.1

Miller Children's Hospital

562.661-1158

Region 7

Inland Counties Region

909.558.3996

Region 8

Orange County Region

562.945.6484

Region 9

San Diego & Imperial Counties

858.536.5090

Region 10

Kaiser Permanente System-North

408.366.4101

Region 11

Kaiser Permanente System-South

951.353.3569

CDAPP Resource Center

858.536.5090

Educational Opportunities

November 1-3, 2012, Sweet Success 2012: Partnering for Prevention Research Conference, Anaheim, Ca. More information visit http://www.sweetsuccessexpress.com/conferences.htm

Place postage here

CDAPP Sweet Success©

California Diabetes and Pregnancy Program

Regional Program Address