Breaking Ward Walls; Leading Multidisciplinary Collaboration in Inpatient Diabetes Care

2026 North Country Leadership Summit

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Disclosure Information:

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2026 North Country Leadership Summit

- I have no relevant financial relationships to disclose.
- I will not discuss off label use or investigational use in my presentation.

Learning Objectives

- Describe key principles of collaborative leadership and how they can be applied without formal leadership authority.
- Identify strategies for breaking down departmental silos and building effective interdisciplinary partnerships around complex patient-care needs.
- Develop an actionable approach to advocating for system-level change by identifying a gap, engaging stakeholders, and translating collaboration into sustainable processes and improved outcomes.

Champlain Valley Physicians Hospital- Plattsburgh, New York

300-bed level III trauma center that serves 87,000 people across New York's North Country.

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New York's Diabetes Epidemic

DIAGNOSED DIABETES PREVALENCE

1,906,000

adults-10.8% of adult population have diagnosed diabetes

ANNUAL NEW DIAGNOSIS

124,000

adults are diagnosed each year

ESTIMATED UNDIAGNOSED ADULTS

1 IN 4

adults with diabetes are unaware of their condition- about 476,000 New Yorkers

CHRONIC CONDITION MANAGEMENT

12%

of Clinton County residents with chronic conditions have completed a management course

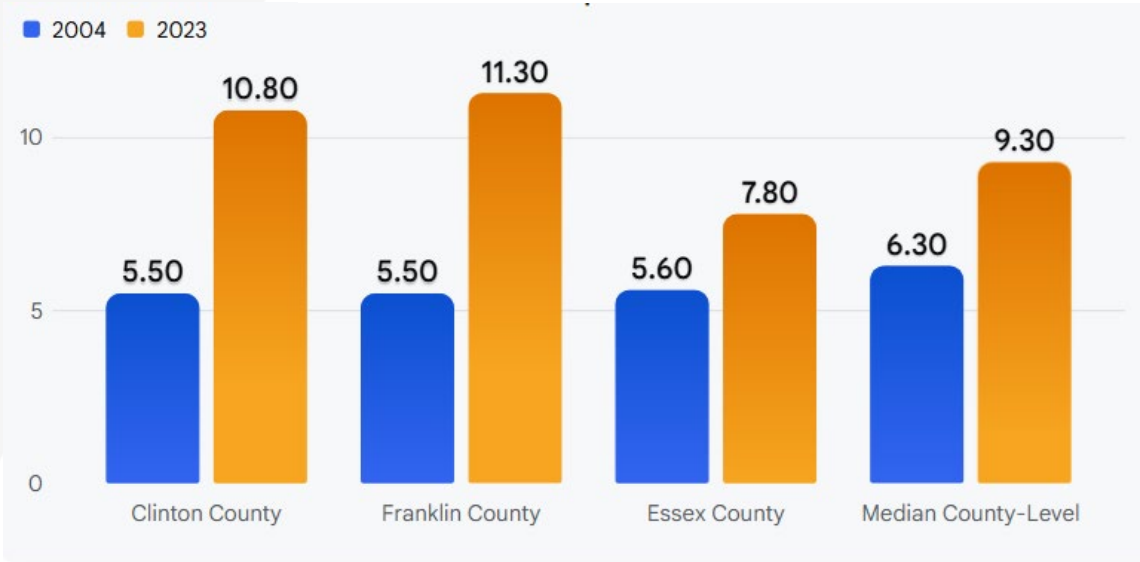
HOSPITALIZATIONS WITH A DIABETES DIAGNOSIS

1 in 4

2020-21, about 27.3% of all adult hospitalizations in the United States had a listed diabetes code.

Diabetes prevalence comparison from 2004- 2023

Entity	2004 Prevalence	2023 Prevalence	Absolute Increase
Franklin County	5.5%	**11.3%**	**+5.8%**
Clinton County	5.5%	**10.8%**	**+5.3%**
Median County-Level	**6.3%**	**9.3%**	**+3.0%**
Essex County	5.6%	**7.8%**	**+2.2%**



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One patient. One hospitalization. Many departments.

The patient experiences one journey. The system experiences multiple silos.

What Is Collaborative Leadership?

Leadership is not limited to the person with the title.

- Identify a problem worth solving.
- Build relationships across boundaries.
- Create shared ownership.
- Connect people, expertise, and resources.
- Move an idea from conversation to action.

Leader = the person who creates movement.

The Silo Problem.

Silo Thinking

- “That's not our job.”
- “We've always done it this way.”
- “My department.”
- Individual responsibility
- Fix the immediate problem

Collaborative Thinking

- “Who needs to be involved?”
- “Is this working?”
- “Our patient.”
- Shared accountability
- Fix the system

The Gap I Couldn’t Ignore.

Sometimes leadership starts with seeing the same problem one too many times.

The Gap I Couldn’t Ignore

Before the position existed..

- Patients were being diagnosed with diabetes in the hospital.
- Staff had varying levels of diabetes knowledge and confidence.
- Diabetes technology created new clinical questions.
- Protocols did not always reflect updates and changes to diabetes care standards.
- Education was inconsistent.
- There was no dedicated inpatient diabetes educator.

I kept seeing the same gap — and eventually realized someone had to own it.

The questions kept repeating..

How should we manage this patient's pump?

Can the patient continue using their CGM?

What does nursing need to document?

What happens when the patient is NPO?

Who is responsible for diabetes education?

How do we prepare the patient for discharge?

The problem was bigger than any one patient.

The question that changed everything.

“What if we had someone whose job was to connect all of this?”

Not “I want a new position.” → “Our patient’s have a need that isn’t currently being met.”

Advocacy is Leadership

Turning a gap into a case for change

1	2	3	4	5	6
IDENTIFY	**COLLECT**	**BUILD**	**PRESENT**	**ADDRESS**	**GAIN**
the problem	evidence	relationships	the opportunity	concerns	support

Advocacy becomes leadership when it creates movement beyond yourself.

I Didn’t Do It Alone

The position started with one identified need. The solution required many people

From position to partnership.

The First Day Wasn’t the Finish Line

The next challenge was credibility.

LISTEN

Understand the workflow before changing it.

LEARN

Respect the expertise already in the room.

CONNECT

Find the people who can move the work forward.

FOLLOW THROUGH

Do what you say you will do.

People don't need another person telling them what they're doing wrong.

Meet People where they are?

Different departments have different priorities — and all of them matter.

NURSING	PHARMACY	DIETARY	MEDICINE	SURGERY / ANESTHESIA
• Workflow	• Medication safety	• Nutrition	• Diagnosis	• Periop safety
• Staffing	• Formulary	• Meal timing	• Treatment	• NPO management
• Safety	• Insulin management	• Carbohydrate mgmt	• Clinical outcomes	• Technology

Same patient. Different perspectives.

Collaboration isn’t consensus

Collaboration does not mean everyone agrees.

- Everyone has a voice
- Concerns are heard
- Expertise is respected
- Decisions remain patient-centered
- People understand the “why”

From Collaboration to Action

Relationships become leadership when they change the way work gets done.

From Conversations to Systems

EDUCATION
Patients + staff

PROTOCOLS
Standardize care

TECHNOLOGY
Support modern diabetes tools

COMMUNICATION
Connect departments

STANDARDIZATION
Reduce variation

OUTCOMES
Measure the difference

The goal is not to be the expert in the room. The goal is to connect the expertise in the room.

Educating the Patient

Hospitalization can be a missed opportunity– or a teachable moment.

- Diabetes self-management
- Insulin administration
- Glucose monitoring
- Hypoglycemia recognition and treatment
- Diabetes technology
- Sick-day management
- Discharge preparation

Education is not an add-on. It is part of safe transition home.

Educating the Staff

Confidence grows when people know what to do — and where to turn.

- Insulin safety
- Hypoglycemia management
- CGM awareness
- Insulin pumps and automated insulin delivery
- Glucose monitoring
- Patient self-management in the hospital
- Perioperative diabetes considerations

You can't expect staff to confidently manage technology they haven't been taught to understand.

Diabetes Technology Changes the Conversation

A CGM or insulin pump turns one patient's care plan into a multidisciplinary workflow.

Standards of Care

Insulin Pump Use in the Hospital

Recommendation

16.7 Continue use of insulin pump including automated insulin delivery in people with diabetes who are hospitalized when clinically appropriate. This is contingent upon availability of necessary supplies, resources, training, ongoing competency assessments, and implementation of institutional diabetes technology protocols. **C**

American Association of Clinical Endocrinologists (AACE) offers similar statements & Support of continued diabetes technology use

Diabetes Care in the Hospital- Standards of Care

American Diabetes Association

2026 Standard of Care

The Technology Problem

A patient arrives wearing technology. Suddenly, everyone has a question.

CGM

INSULIN PUMP

AUTOMATED INSULIN DELIVERY

- Can the patient continue using it?
- What should nursing document?
- Who is responsible for oversight?
- What happens during procedures, imaging, or NPO status?

The technology doesn’t belong to one department

It belongs in a shared care process

Creating Protocols that Support Technology

Move from “We don't allow it because we don't have a process” to “How can we safely support it?”

- CGM and patient-owned technology
- Insulin pumps / automated insulin delivery
- Documentation expectations
- Nursing responsibilities
- Provider oversight
- Procedures and imaging
- Perioperative considerations

Protocols turn uncertainty into a shared language.

Protocols Create Confidence

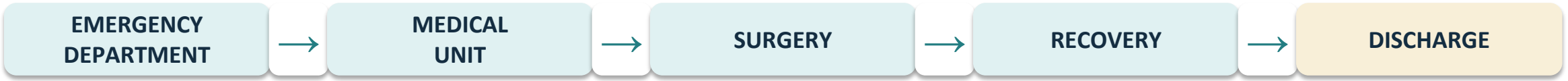
QUESTION → UNCERTAINTY → VARIATION → RISK

QUESTION → PROCESS → CONSISTENCY → CONFIDENCE

Break the Boundary, Not the Workflow

Diabetes care doesn't stop at the unit door.

One Patient, Multiple Doors



Diabetes doesn't stop at the unit door. Why should our collaboration?

Emergency Room Collaboration.

- Early identification of diabetes-related needs.
- Technology considerations.
- Consistent education and communication.
- Appropriate transitions to inpatient care.
- Clear escalation pathways.

The ED is often the first doorway into the hospital system.

Surgical & Perioperative Collaboration

- Pre-op diabetes planning
- NPO and insulin considerations
- CGM / pump considerations
- Anesthesia communication
- Post-op glucose management
- Safe transition back to the patient's usual diabetes plan

The handoff is not the end of collaboration. It is where collaboration matters most.

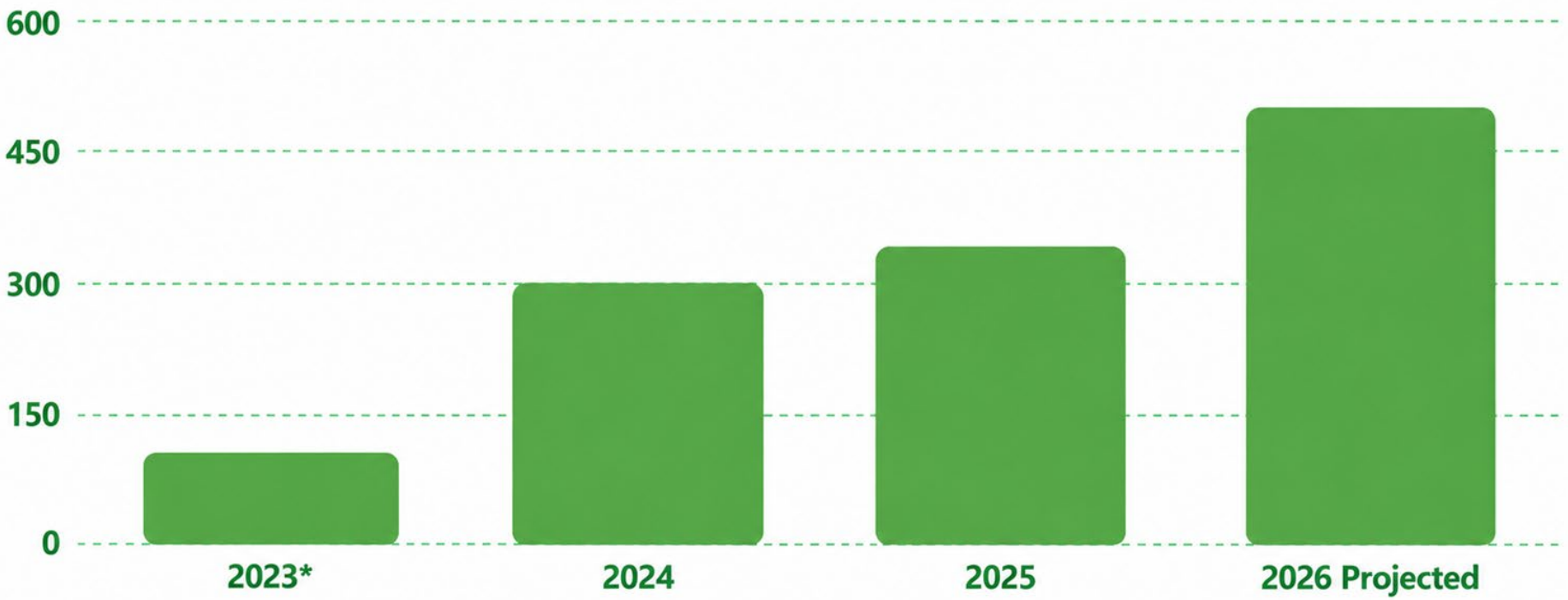
Show the Change.

Collaborative leadership becomes sustainable when we can demonstrate what changed.

Consults

Diabetes Education Consults: Actual and Projected Growth

Annual diabetes education consults from 2023 through 2025, with 2026 projected based on the January–August 2026 average monthly volume.



2026 projection assumes the January–August average of 41.5 consults/month continues through December.

From “I think we’re better” to “we can show it”

PATIENT OUTCOMES

- Hypoglycemia
- Hyperglycemia
- Length of stay
- Readmissions
- Diabetes knowledge

STAFF OUTCOMES

- Education completion
- Knowledge
- Confidence
- Protocol adherence

SYSTEM OUTCOMES

- Technology processes
- Protocol implementation
- Consult volume
- ED / surgical integration

What has changed?

DIABETES EDUCATION

Before:
Inconsistent

Today:
CDCES Access and patient consults

STAFF EDUCATION

Before:
Outdated

Today:
Tailored to the needs of staff, updated on new guidelines/ Standards of care

CGM / PUMP PROCESSES

Before:
none

Today:
Policy and Continued Device Use!

COLLABORATING DEPARTMENTS

Before:
Lacking

Today:
We are increasing collaboration and improving our care

3 years later….

ED	NURSING	PHARMACY	SURGERY	PATIENT
Knows what to do	Has a process	Understands the plan	Has a technology pathway	Receives consistent education

That's what collaborative leadership looks like.

What I have learned about Leadership

The title came later, the leadership started much earlier.

Five Lessons from the Journey

1. Start with the problem, not the position.
2. Build relationships before asking for change.
3. Bring people into the solution.
4. Learn to adapt.
5. Remember how far you have come

YOU DON’T NEED PERMISSION TO START LEADING

Leadership can begin long before the title does.

Find Your Silo.

Where is the disconnect in your organization?

- Communication
- Medication safety
- Discharge / transitions
- Patient education
- Technology
- Documentation
- Staffing
- Something else

Turn the Problem into a question.

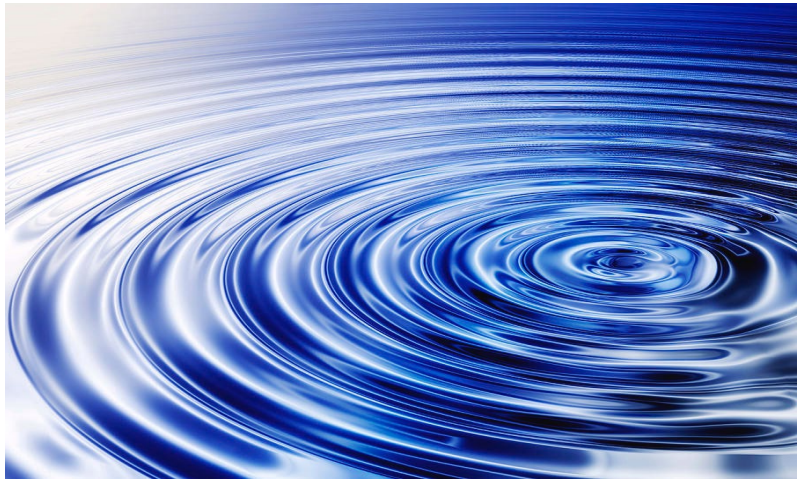
“Nobody communicates.”	→	“Where does communication break down?”
“We need another position.”	→	“What patient need isn't currently being met?”
“That department doesn't help us.”	→	“What barrier is preventing us from working together?”

Your Leadership Doesn’t Have to Look Like Everyone Else’s

You don't have to be the person in charge to be the person who starts the change.

- See the gap
- Start the conversation
- Bring the right people to the table, or invite yourself to theirs.
- Create a shared goal
- Build the process
- Measure the difference

The Ripple Effect.



ONE PERSON	→	CONVERSATION	→	RELATIONSHIPS	→	TEAM	→	PROCESS	→	SYSTEM	→	PATIENTS
identifies a gap		begins		develop		forms		changes		improves		benefit

Individual advocacy can become organizational change.

BREAK THE SILO.

BUILD THE RELATIONSHIP.

CREATE THE SYSTEM.

IMPROVE THE OUTCOME.

Collaborative leadership starts with seeing a problem — and believing it can be different.

People are People..

The moment you start putting someone on a pedestal, you stop showing up as yourself.

When it’s my turn to speak, I speak.

I ask the question.
I share the idea.
I contribute to the conversation.

Not because i know everything.
Because I know I know I have something to offer.

-LeeAnne Ruff

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Thank you.

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