Optimizing Care Transitions of Older Adults with Diabetes

Welcome!

- All lines are muted, please ask your questions in Q&A
- For technical issues, chat to the 'Technical Support' Panelist
- Please actively participate in polling questions that will pop up on the lower righthand side of your screen

We will get started shortly!

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

ALLIANT QUALITY
The Quality Improvement Services Group of
ALLIANT HEALTH SOLUTIONS

Optimizing Care Transitions of Older Adults with Diabetes

July 22, 2021

Presented by:
Jacqueline LaManna, PhD, APRN, ANP-BC, BC-ADM, CDCES, FADCES

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

ALLIANT QUALITY

Carolyn Kazdan, MHSA, NHA

AIM LEAD, CARE COORDINATION

Ms. Kazdan currently holds the position of Director, Health Care Quality Improvement for IPRO, the Medicare Quality Improvement Organization for New York State. Ms. Kazdan leads IPRO's work with Project ECHO® and serves as the Care Transitions Lead for Alliant Quality. Ms. Kazdan previously led the IPRO's work with the NYS Partnership for Patients and the Centers for Medicare & Medicaid Services (CMS) Special Innovation Project on Transforming End of Life Care in the Nassau and Suffolk County region of New York State. Prior to joining IPRO, Ms. Kazdan served as a Licensed Nursing Home Administrator and Interim Regional Director of Operations in skilled nursing facilities and Continuing Care Retirement Communities in New York, Pennsylvania, Ohio and Maryland. Ms. Kazdan has served as a senior examiner for the American Healthcare Association's National Quality Award Program, and currently serves on the MOLST Statewide Implementation team and Executive Committee. Ms. Kazdan was awarded a Master's Degree in Health Services Administration by The George Washington University.

Carolyn enjoys visiting her grandchildren, photography, crocheting, needlepoint, reading and being at the beach!

"I don't have to chase extraordinary moments to find happiness - it's right in front of me if I'm paying attention and practicing gratitude"

–Brene Brown

Contact: ckazdan@ipro.org

Jacqueline LaManna

PhD, APRN, ANP-BC, BC-ADM, CDCES, FADCES

ASSOCIATE PROFESSOR
UNIVERSITY OF CENTRAL FLORIDA, COLLEGE OF NURSING

Dr. LaManna is an Associate Professor in the University of Central Florida's College of Nursing. She is the Program Director of the post-master's Doctor of Nursing Practice program and instructs in the primary care nurse practitioner program. Dr. LaManna received her BSN from Purdue University, MSN from the University of Florida, and PhD from the University of Central Florida. Her dissertation work examined care transition experiences of older adults with diabetes. Dr. LaManna is certified as an adult nurse practitioner and diabetes care and education specialist and is board-certified in advanced diabetes management. She is a Fellow in the Association of Diabetes Care and Education Specialists. Dr. LaManna has published and presented nationally on diabetes-related topics. She maintains a supplemental clinical practice in a public health department based endocrine specialty clinic for women experiencing diabetes-complicated pregnancies.

Contact: jacqueline.lamanna@ucf.edu

Objectives

- Learn Today:
  - Describe patient-related factors that add complexity to care transitions of older adults with diabetes.
  - Discuss system-related factors that may contribute to poor transition outcomes in older adults with diabetes.
  - Discuss strategies to optimize effective home transitions of older adults with diabetes.
- Use Tomorrow:
  - Review your facility's transitional care process and identify one strategy to implement that would improve your process.

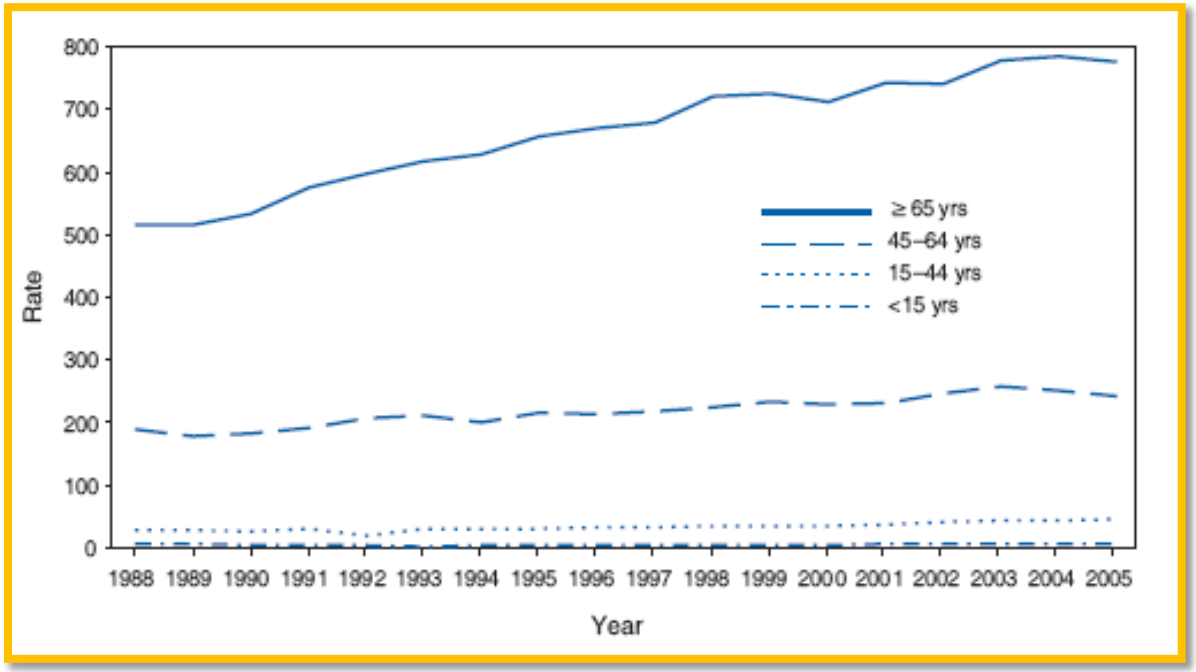
Profile of the Hospitalized Patient With Diabetes

Patients with diabetes are:

- Older
  - ¼ of people over the age of 65 are affected by diabetes
  - More likely than any other patient group to experience a hospitalization
  - 5 million hospitalizations of adults with diabetes annually

Profile of the Hospitalized Patient With Diabetes

Annual Diabetes Rate/10,000 Population Among Patients Discharged from Hospitals, by Year and Age Group — National Hospital Discharge Survey, United States, 1988–2005



Profile of the Hospitalized Patient With Diabetes

Persons with diabetes are:

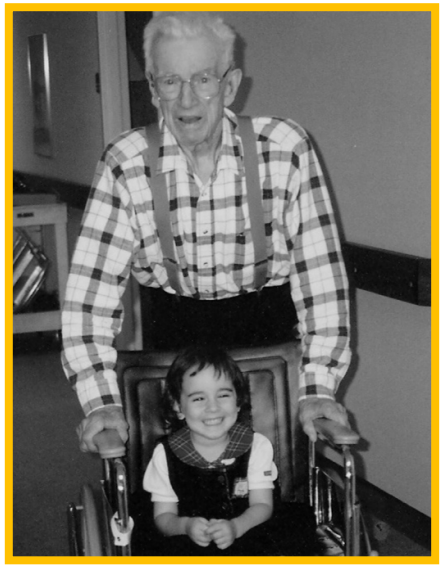
- more likely to be affected by multi-morbidity
  - Increases complexity of treatment plans – drug/drug and drug/disease interactions
  - Diabetes is often not addressed in non-diabetes chronic disease algorithms

Profile of the Hospitalized Patient With Diabetes

Persons with diabetes are:

- more likely to be affected by a geriatric syndromes

  - Cognitive impairment
  - Depression
  - Urinary incontinence
  - Falls
  - Pain
  - Functional disability and dependency
  - Polypharmacy



Profile of the Hospitalized Patient With Diabetes

Persons with diabetes are

- most likely to be hospitalized for a condition other than diabetes
- likely to experience illness-related episodes of hyperglycemia
- more likely to experience a longer length-of-stay and higher hospital costs

Profile of the Hospitalized Patient With Diabetes

Patients with diabetes are:

- more likely to experience an event of unplanned healthcare utilization after discharge.
  - 10-30% readmission for older adults with diabetes
  - Predictors in diabetes population
    - Type 2 diabetes diagnosis that precedes admission
    - Escalation of diabetes treatment regimen (*strongest predictor*)
    - Pre-admission history of heart failure
    - Pre-admission history of a recent in-patient visit

Eby, E., et al. (2015). Predictors of 30-day hospital readmission in patients with type 2 diabetes: A retrospective, case control, database study.
Current Medical Research and Opinion, 31*, 107-114*

Profile of the Hospitalized Patient With Diabetes

- **Patients with diabetes are:**
  - likely to have ongoing care needs following discharge.
  - more likely to experience a medical error at home.
    - Error rate is 5 to 6 times that of hospital and most likely to occur within the 24 hours of discharge
    - Anti-hyperglycemic mismanagement is common contributor to medical errors
    - Highest in patients prescribed 7 or more medications at discharge

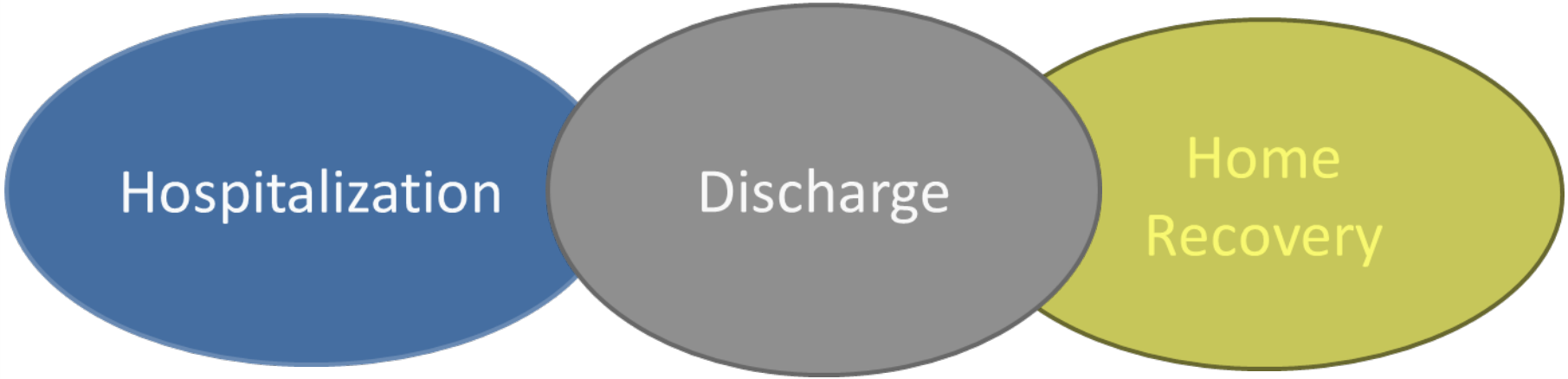
Diabetes Treatment in the Acute Care Setting

- **Provider other than the patient's primary care provider.**
- **Integration of multiple protocols**
  - Often includes discontinuation of home diabetes medications
- **Increasing treatment complexity and more accountability on the bedside providers**
  - High risk for errors

Diabetes Treatment in the Acute Care Setting

- Changes in diabetes treatment plan at discharge are common.
- Care providers often underestimate patient understanding of medication education.

Hospitalization and Transition



Three overlapping transitions processes where patient and family attempt to reconstruct a sense of normalcy.

Goals in Hospital-to-Home Transition

- Restructure self-concept
- Resume prior roles
- Integrate knowledge and skills to manage health and illness and change
- Return day-to-day health management responsibilities to patient and family caregivers.
- Achievement of competency with self-management and coping behaviors

***May be difficult for older adults with residual health problems and functional deficits.**

Elements of Effective Post-Hospital Transitions

- Accurate provider communication
- Preparation of the patient and caregiver for next level of care
- Reconciliation of medication regimens
- Patient and caregiver involvement in decision making
- Education on signs and symptoms of significant clinical changes

Results of Poorly-Executed Transitions

- Mortality
- Readmission
- Emergency room utilization
- Unplanned provider visits
- Medical errors
- Personal injury
- Living situation instability
- Coping difficulties

Common Post-Discharge Coping Difficulties

- Increased dependence on others to meet personal and self-care needs
- Greater reliance on others to perform household tasks
- Difficulty with medication management
- Lack of information on support services and how to engage them

Common Post-Discharge Coping Difficulties

- Unmet information needs
- Poor understanding of symptom management
- Fatigue
- Anxiety
- Depression
- Poor perceptions of care

Transition Difficulties Encountered by Patients with Diabetes

- Modification of complex medication regimens
- Inadequate knowledge of intricate meal-planning skills
- Lack of knowledge of medications
- Limited access to disease-related equipment
- Poor care coordination
- Risk of hypoglycemia increasing risks of falls and injury

Optimizing Care Transitions for Patients with Diabetes

- Obtain accurate information at time of admission:
- Baseline A1c
- Baseline creatinine
- Baseline lipids
- Baseline weight/BMI
- Management of other conditions

Optimizing Care Transitions for Persons with Diabetes

- Assess baseline diabetes knowledge and home self-care practices.
- Patient education should commence during admission
- Patient education should continue throughout stay.
- Better retention if material is divided in shorter sessions.
- Consider methods used and individualize.
- Home insulin pump parameters and management if appropriate

Optimizing Care Transitions for Persons with Diabetes

- **Provide opportunities to practice self-management**
  - Self-monitored blood glucose
  - Insulin administration or use of pen delivery system
  - Calculation of carbohydrate/insulin dose if indicated
- **Reinforce glucose targets**
  - Patients often become frustrated with glucose control after discharge and need to understand the whys for this.

Optimizing Care Transitions for Persons with Diabetes

- **Identify factors that may impact self-care abilities**
  - Functional deficits
    - Blindness
    - Hearing deficit
    - Cognitive deficit/memory deficits
  - Psychosocial/social barriers
    - Lack of access to resources/support
    - Living alone
    - Work/schedule irregularities
    - Depression/pre-existing mental health issues
    - Health literacy and numeracy

Optimizing Care Transitions for Persons with Diabetes

- **Educate on how to handle common issues seen at home**
  - Nausea
  - Pain management
  - Activity limitations
  - Resumption of other chronic illness treatment plans
- **Highlight changes in medication regimens**
  - Most difficulties occur when patient can't identify discontinued medications
- **Use teach back methods to assess understanding**

Optimizing Care Transitions for Persons with Diabetes

- **Ensure prescriptions are provided:**
  - Medications
  - Injectables
  - Syringes or pen needles
  - Blood glucose testing equipment
  - Ketone test strips*
  - Glucagon emergency kit*
- **Follow-up care**
  - Follow-up appointments
  - Reportable signs and symptoms

Mobilize the Team Early!

- Family care providers
- Case management
- Social work
- Clinical dietitians
- Pharmacists
- Rehabilitation therapists
- Diabetes educators
  - In-patient
  - Community based
- Home care

Follow-Up Recommendations

- **Phone follow-up within 2 days of discharge is helpful**
  - Improves patient satisfaction
  - Improves medication adherence
  - Decreases preventable adverse drug events
  - Decrease in emergency department visits
  - Decrease in readmission
  - Aids in anticipation of treatment changes which may create confusion
- **Effective transfer of accurate discharge information to follow-up providers is essential**

Final Thoughts

- Diabetes is a common condition that adds complexity to the post-discharge experiences of affected individuals.

- Even a short-term stay for a perceived minor condition, may have significant impact on the home recovery transitions of people with diabetes

Objectives Check In!

- **Learn Today:**
  - Describe patient-related factors that add complexity to care transitions of older adults with diabetes.
  - Discuss system-related factors that may contribute to poor transition outcomes in older adults with diabetes.
  - Discuss strategies to optimize effective home transitions of older adults with diabetes.
- **Use Tomorrow:**
  - Review your facility's transitional care process and identify one strategy to implement that would improve your process

How will this change what you do?

Please tell us in the poll…

Closing Survey

Help Us Help You!

- Please turn your attention to the poll that has popped up in your lower right-hand side of your screen
- Completion of this survey will help us steer our topics to better cater to your needs

CMS 12th SOW Goals

Behavioral Health Outcomes & Opioid Misuse

- ✓ Promote opioid best practices
- ✓ Decrease high dose opioid prescribing and opioid adverse events in all settings
- ✓ Increase access to behavioral health services

Patient Safety

- ✓ Reduce risky medication combinations
- ✓ Reduce adverse drug events
- ✓ Reduce C. diff in all settings

Chronic Disease Self-Management

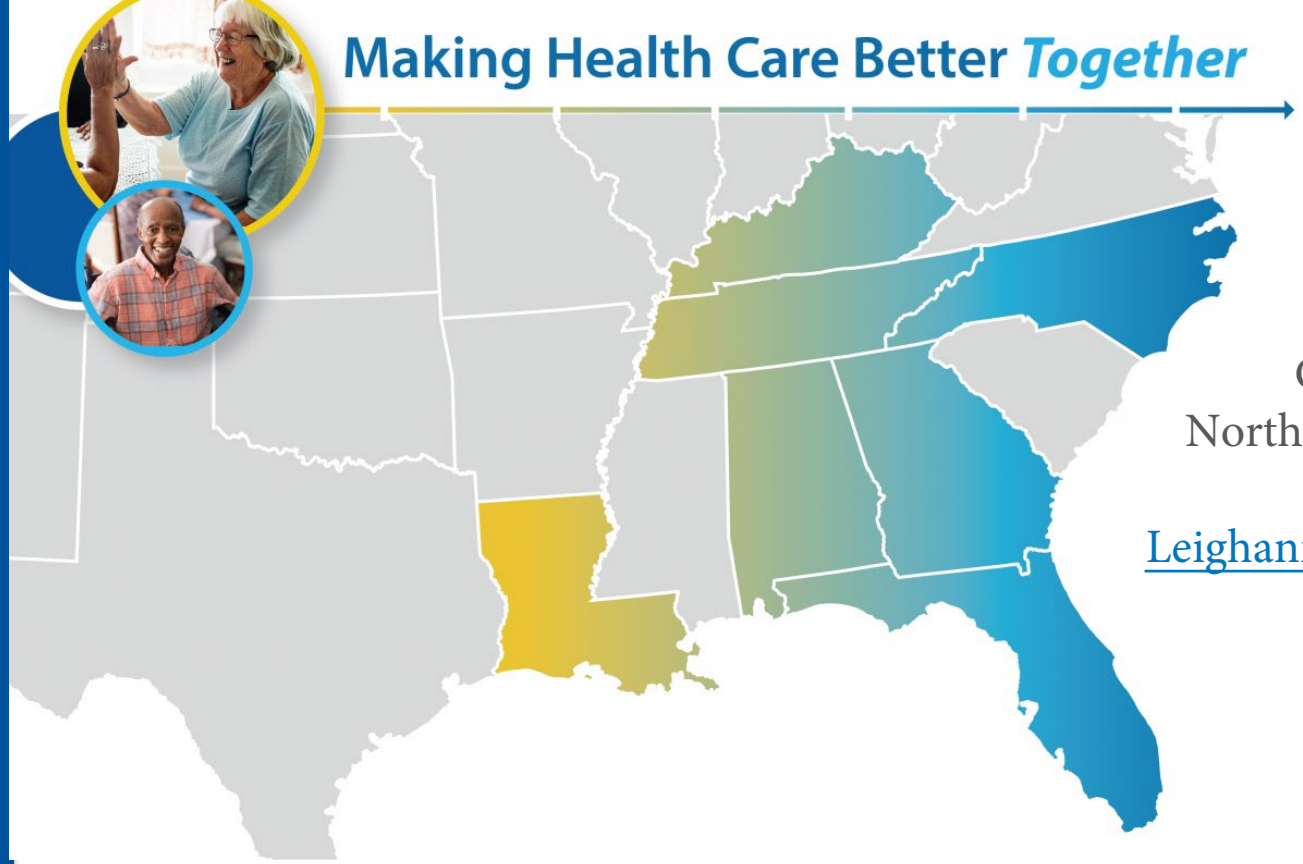
- ✓ Increase performance on ABCS clinical quality measures (i.e., aspirin use, blood pressure control, cholesterol management, cardiac rehab)
- ✓ Identify patients at high-risk for developing kidney disease & improve outcomes
- ✓ Identify patients at high risk for diabetes-related complications & improve outcomes

Quality of Care Transitions

- ✓ Convene community coalitions
- ✓ Identify and promote optical care for super utilizers
- ✓ Reduce community-based adverse drug events

Nursing Home Quality

- ✓ Improve the mean total quality score
- ✓ Develop national baselines for healthcare related infections in nursing homes
- ✓ Reduce emergency department visits and readmissions of short stay residents



Program Directors

Georgia, Kentucky,
North Carolina and Tennessee
Leighann Sauls
Leighann.Sauls@AlliantHealth.org

Alabama, Florida and Louisiana
JoVonn Givens
JoVonn.Givens@AlliantHealth.org

Upcoming Events

Learning and Action Webinars

Nursing Homes Tuesdays, 2pm ET/1pm CT	**Community Coalitions** Thursdays, 12:30 pm ET/11:30am CT
August 17, 2021: Immunizations Let's get back to basic immunization practices: Assessment | Recommendation | Administration | Documentation	August 26, 2021: Optimizing Care Transitions of Older Adults with Diabetes: Session 2 with Dr. Jacqueline LaManna
September 21, 2021: Diagnostic Stewardship for C. difficile Prevention	September 23, 2021: Optimizing Care Transitions of Older Adults with Diabetes: Session 3 with Dr. Jacqueline LaManna

Making Health Care Better *Together*

ALABAMA • FLORIDA • GEORGIA • KENTUCKY • LOUISIANA • NORTH CAROLINA • TENNESSEE

ALLIANT HEALTH SOLUTIONS

@AlliantQualityOrg

Alliant Quality

@AlliantQuality

Alliant Quality

This material was prepared by Alliant Quality, the quality improvement group of Alliant Health Solutions (AHS), the Medicare Quality Innovation Network - Quality Improvement Organization for Alabama, Florida, Georgia, Kentucky, Louisiana, North Carolina, and Tennessee, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this document do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement or that product or entity by CMS or HHS. Publication No. 12SOW-AHSQIN-QIO-TO1CC-21-867-07/14/21

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

ALLIANT QUALITY
The Quality Improvement Services Group of
ALLIANT HEALTH SOLUTIONS