“Daunting”- Discharge Experience Perspectives from Older Adults with Diabetes

Welcome!

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We will get started shortly!

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“Daunting”- Discharge Experience Perspectives from Older Adults with Diabetes

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Presented by:

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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

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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.

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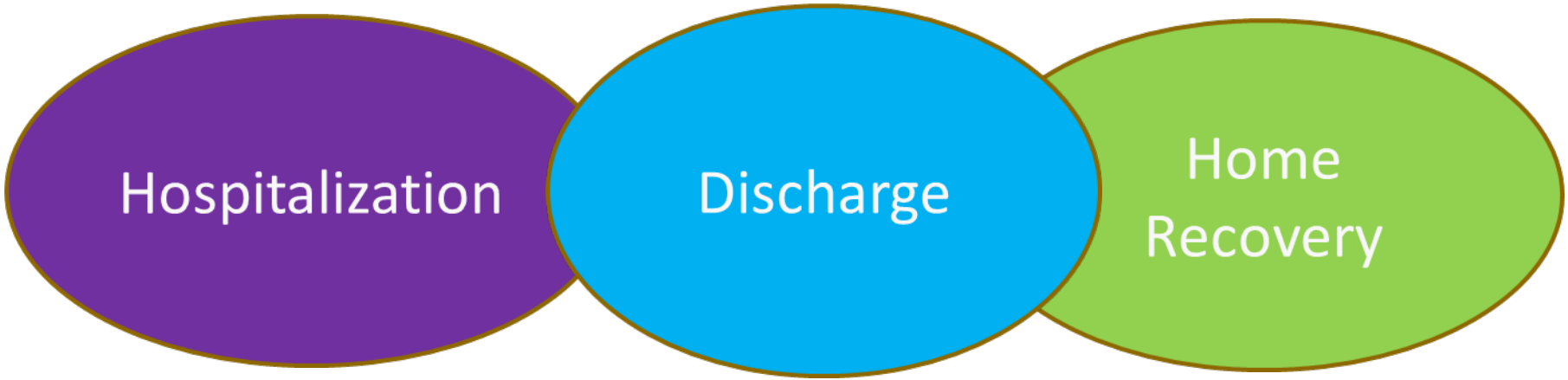
Objectives

- Learn Today:
  - Learn what Older Adults and their Care Partners identify as readmission risks and the challenges of the transition process
  - Understand the impact of care transitions and the patient experience on customer experience scores
  - Identify opportunities for process improvement from qualitative data on post discharge interviews
- Use Tomorrow:
  - Review your facility's transitional care process and identify one strategy to implement that would improve your process.

Recap from Part 1: Hospitalization and Transition



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

Recap from Part 1

- Older adults with diabetes (DM):
  - utilize 16.5 million in-patient hospital days annually.
  - have higher prevalence of multimorbidity.
  - are at increased risk for development of geriatric syndromes.
  - are typically hospitalized for a condition other than diabetes.
  - must self-manage dynamic, technically complex treatment regimens, often for multiple conditions.
  - are more likely to require help with basic care.

Recap from Part 1

- Home recovery transition is a period of heightened vulnerability.
- Home recovery needs of elders with DM exceed those that preceded hospitalization:
  - Glycemic control often deteriorates in hospital.
  - Modifications of treatment plans.
  - New therapies for emerging health problems.
  - Changes in functional status.
  - Adverse event risk 5 to 6 times greater at home.
  - 50% of recently discharged may experience a medication error.

Recap from Part 1

- Older adults with DM experience higher rates of recidivism.
  - Over 30% experience readmission within 30 days of discharge.
- Care transition measures now incorporated into HCAPS.
  - Nationally 50% of patients "Strongly Agree" that they understood discharge instructions.
- Transitional care needs of people with DM are poorly understood.

Study Aims

- Determine what factors are associated with development of home recovery transition difficulties in a sample of older adults with a pre-existing diagnosis of diabetes.

- Describe and add specificity to the common problems and difficulties encountered by older adults with diabetes during the early (7-day) and intermediate (30-day) post-discharge transition periods.

Study Aims

- Determine if post-discharge difficulties encountered by older adults and family caregivers differ in the early and intermediate transitional periods following hospitalization.

- Determine if any of these factors are predictive of poor transition outcomes during the home recovery transition.

Methodology

- Simultaneous quantitative/qualitative mixed methods design

- Three recurrent subthemes from qualitative analyses transformed to individual dichotomous variables and subjected to statistical testing.

Methodology

- Inclusion criteria
  - Age > 65 years of age
  - Diagnosis of diabetes that predated hospitalization
  - Length-of-stay of > 48 hours
  - Planned discharge home within 4 hours of study enrollment
  - Ability to hear, speak, understand and read English
  - Telephone access for 30 days following discharge

- Exclusion criteria
  - Medical or medication history suggestive of pre-existing cognitive deficit
  - Planned discharge to facility or hospice services

Methodology - Measures

- Health Status
  - Age
  - Chronic Illness Burden
  - Cognitive Status
    - Mini-Cog
  - Functional Status
    - Katz-ADL
- Diabetes-Related Factors
  - Duration of DM
  - A1C
  - Use of insulin
  - Change in DM treatment
  - DM-related Complications

— Readiness for Hospital Discharge (Weiss & Piancentine, 2006)

- Readiness of Hospital Discharge Scale ($\alpha = .820$)
- Recently revised short form for patient, RN, providers
- RN version predictive of readmission

Methodology - Measures

- Hospital Discharge Factors
  - Length-of-stay
  - Hospitalist Services
  - Change in treatment
  - Quality of Discharge Teaching Scale (Weiss et al., 2007) (α = .775)
    - Content Needed
      - (α = .804)
    - Content Received
      - (α = .677)
    - Delivery
      - (α = .775)
- In-home caregiver
- Home health referral

Methodology - Measures

Transition Outcomes:

- Unplanned Healthcare Utilization
  - Readmission
  - Emergency Department Visit
  - Unplanned Provider Visit

- Perceived Transition Quality
  - Care Transition Measure-15 (Coleman)
    (α = .966)

- Post-Discharge Coping Difficulties (Weiss et al., 2007)
  - Post-discharge Coping Difficulty Scale Scores 7 days
    - (α = .916)
  - Post-discharge Coping Difficulty Scale Scores 30 days
    - (α = .921)
  - Difficulty Managing Medications
  - Difficulty Controlling Glucose
  - Difficulty Managing Chronic

Respondent Profile

- Free response data provided by 67 participants during 7-day follow-up and 55 participants at 30-day follow-up.

- General Characteristics of Respondents
  - Median age 75 years.
  - Genders equally represented.
  - Primarily Caucasian (n = 59; 88.1%)
  - Cardiovascular condition (n = 17, 25.4%)
  - Non-cardiovascular medical diagnosis (n = 32, 47.8%)
  - General surgical diagnosis (n = 18, 26.9%)
  - Pre-existing DM-related chronic condition (n = 57, 85%)

Respondent Profile

- Multimorbidity profile
  - Diabetes-related multimorbidity > 75%
  - Coronary artery disease (n = 40; 59.7%)
  - Chronic kidney disease (n = 28; 41.8%)
  - Heart Failure (n = 24; 35.8%)
  - Neuropathy (n = 37; 55.2%)

- Diabetes-related health characteristics
  - Median A1c = 6.82% (SD = 1.06)
  - 32.8% (n = 23) prescribed insulin at discharge
  - 41.8% (n = 25) with change in diabetes treatment plan at discharge

Respondent Profile

- 85.1% (n = 57) of participants had in-home caregiver after discharge
- 52.5% (n = 35) were receiving home care at time of discharge
- 12 of initial 96 participants were lost to follow-up at 7 days and additional 11 at 30 days.
  - More likely to live alone ($p = 0.004$) and have lower self-perceived discharge readiness ($p = 0.005$)

Theme 1: "The Daily Stuff is Difficult"

- Participant response: "I felt emotionally drained when I got home. I felt like I was starting from square one. The daily stuff is difficult."

- Subthemes reported difficulties in:
  - Personal care and household tasks (> 50%)
  - Walking and mobility
  - Transportation
  - Getting supplies and medicines

Theme 2: Engineering Care at Home is Complex

- Caregiver response: "She needed help with basic care and getting her strength and endurance back. I had to clarify her medicines and make sure she could do them herself to be safe at home. I worry about leaving her alone."
- Subthemes
  - "I come last."
    - Participant was caregiver for ill family member
    - Multigenerational caregiving "Sandwich generation" "Double Care"
  - "Doing it alone is difficult."
  - Mobilizing family and support resources
    - Scheduling home care visits created stress
  - "This is rough on my family."

Theme 3: "Life is Stressful."

- Participant response: "I am having bowel movements every 20 minutes all day long. My husband has to do the laundry. My husband and I are fighting. We are also moving out of our house and into a trailer.… There are too many outside influences for me to take care of myself correctly."

- Subthemes:
  - "Too many outside influences."
  - Grief and depression
  - Anxiety and frustration

Theme 4: Difficulties Managing Chronic Health Problems

- Participant response: "I know what to do if my sugar goes high, but have no idea how to manage if it is low. Diabetes medicines have been difficult. They have been changed."

- Subthemes
  - "My diabetes is hard to control."
  - Managing other chronic health problems
  - "So many medicines."
  - "I needed more information."

A Participant's Perspective

"I saw half-a-dozen professionals every day in the hospital at all hours of the day and night. I know this is how a 24-hour operation runs, but it was difficult. I realized I was not grasping large amounts of information and had my wife spend the nights to help with it all and make sure I was not missing anything. It was daunting."

- 69-year-old male admitted with heart failure

Thematic Category	7-day Follow-up $n = 67$		30-day Follow-up $n = 55$	
	%	*n*	%	*n*
"The daily stuff is difficult."	56.7	38	56.3	31
• Personal care and household tasks	44.3	29	41.8	23
• Walking and mobility	17.9	12	18.2	10
• Transportation	4.5	3	12.7	7
• Getting supplies and medicines	4.5	3	0	0
Engineering care at home is complex	52.2	35	43.6	24
• "I come last"	20.9	14	25.5	14
• "Doing it alone is difficult."	3.0	2	7.3	4
• Mobilizing family and support resources	14.9	10	20.0	11
• "This is rough on my family."	34.3	23	18.2	10
"Life is stressful."	22.4	15	29.1	16
• "Too many outside influences."	6.0	4	9.1	5
• Grief and depression	3.0	2	12.7	7
• Anxiety and frustration	16.4	11	12.7	7
Managing multiple complex health problems is difficult	52.2	35	78.2	43
• "My diabetes has been hard to control."	17.9	12	29.1	16
• Managing other chronic health problems	31.3	21	47.3	26
• "So many medicines."	16.4	11	10.9	6
• "I needed more information."	13.4	9	1.8	1

Themes by Transitional Period

Unplanned Healthcare Utilization

- Unplanned healthcare utilization within 30 days of discharge associated with:
  - Difficulty managing medications ($X^2 = 4.653$, $p = 0.031$)
  - Difficulty controlling or managing diabetes ($X^2 = 4.384$, $p = 0.036$)
  - Difficulty managing other chronic health problem ($X^2 = 13.830$, $p < 0.001$)

Coping Difficulty

- Problems managing complex medication regimens, controlling or managing diabetes, and managing other chronic health problems were interrelated.

- Difficulty managing medications after discharge was associated with lower perceptions of transition quality ($t = 2.125$, $df = 71$, $p = 0.037$).

- Difficulty managing a chronic health condition other than diabetes was a predictor of unplanned healthcare utilization (OR = 10.666; $p = 0.004$).

Limitations

- Sample size
- Attrition
- Poor representation of elders who live alone
- Exclusion of elders with cognitive dysfunction
- Lack of cultural diversity
- Comments describing post discharge coping difficulties included subset of participants
- No description of transition experience from participants who were lost to follow-up
- Experiences of caregivers secondarily investigated

Summary

- Home recovery transition is dynamic and needs of the older adult and family caregiver change.
- The post-discharge caregiving situation is fragile.
- Even in “ideal” situation, transition may be difficult.
- As older adults and caregivers attempt to move toward self-sufficiency, they often encounter numerous obstacles following hospitalization.

Summary

- Hospitalization of an older adult stresses multiple individuals in the client's social network.
  - Mental health and coping problems are common after discharge.
- Comorbid health conditions commonly deteriorate late in the home recovery transition.
- Multimorbidity increases the complexity of post-hospitalization self-management.

Practice and Policy Implications

- Incorporation of discharge readiness assessment into transitional care practices to aid at-risk identification.
- Systems to support recently discharged elders and caregivers at multiple points in home recovery transition are needed.
- Transitional care models that exceed 30 days may be optimal.
- Inclusion of post-discharge coping assessment and mental health assessments in ambulatory settings may be useful.
- Establishment of best practices for transitions outside of acute care environments.

Practice and Policy Implications

- Condition-specific approach to readmission reduction may inadequately predict risk for transition difficulties.
- Need to broaden definition of successful transition beyond absence of poor outcomes.
- Enhanced reimbursement for transitional care activities.
- Increase content on transition planning and discharge education in nursing programs.
- Consideration of impacts of transitions during COVID-19 pandemic.

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- Hospital Discharge Scales (Post Discharge Coping Difficulty Scale, all versions): https://www.marquette.edu/nursing/hospital-discharge-scales-post-discharge-coping.php

- Hospital Discharge Scales (Quality of Discharge Teaching): https://www.marquette.edu/nursing/hospital-discharge-scales-quality-of-discharge-teaching-scale.php

Discussion

Objectives Check In!

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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

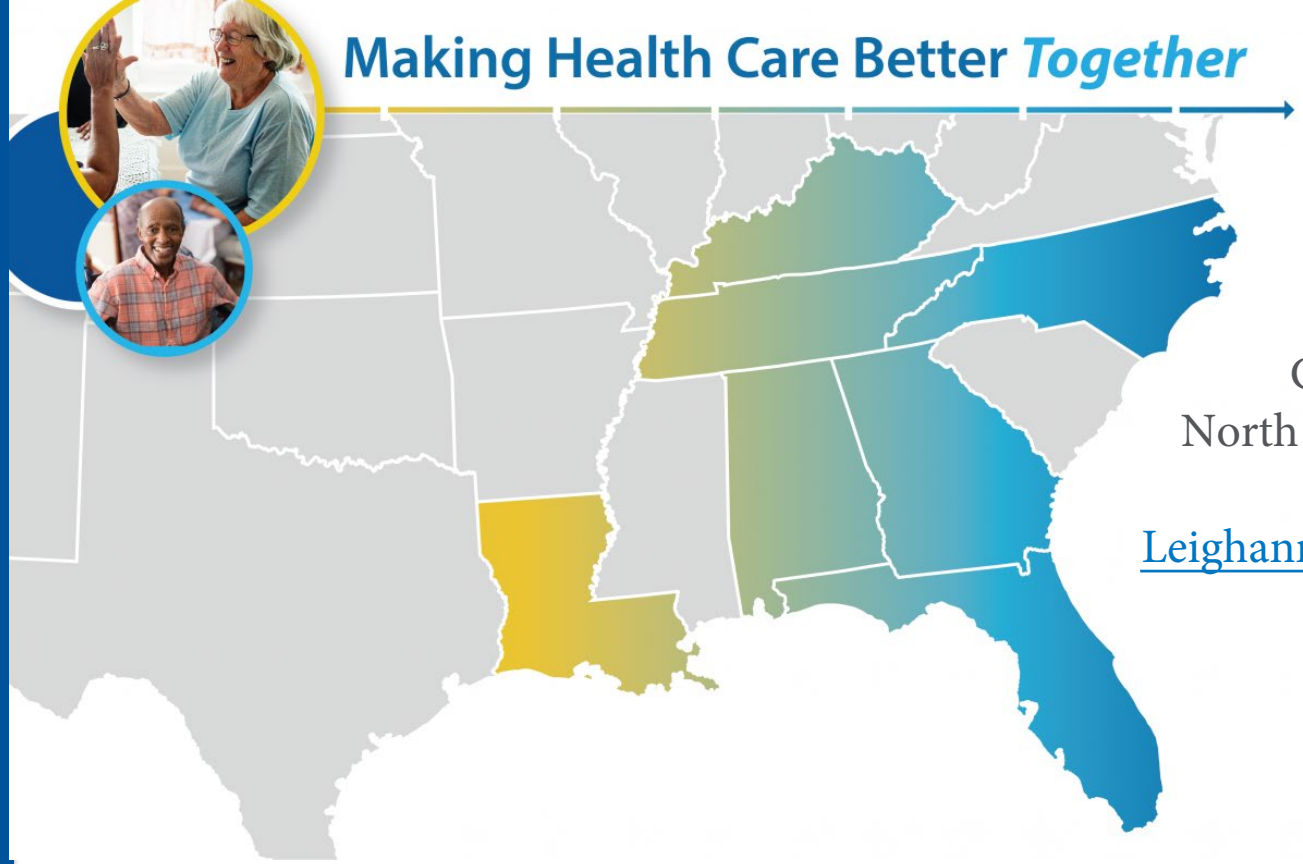
- ✓ Increase performance on ABCS clinical quality measures (i.e., aspirin use, blood pressure control, cholesterol management, cardiac rehab)
- ✓ Identify patients at high-risk for developing kidney disease & improve outcomes
- ✓ Identify patients at high risk for diabetes-related complications & improve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



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Upcoming Events

Learning and Action Webinars

Nursing Homes Tuesdays, 2pm ET/1pm CT	Community Coalitions Thursdays, 12:30 pm ET/11:30am CT
September 21, 2021: F880: Best practices for surveillance, diagnosis, and treatment of C. difficile	September 23, 2021: Care Planning for Successful Transitions During COVID-19: Session 3 with Dr. Jacqueline LaManna
October 19, 2021: UTI Prevention	October 26, 2021: **SPECIAL 1 HOUR EVENT!**

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