Strategies for Better Care Transitions for People with Diabetes

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Learning objectives:

• Describe the need for transitional care
• Define transitions in care
• Identify at least two key factors in making successful transitions in care for people with diabetes
Definition of Transitions of Care

The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.
Patient-Centered Affordable Care Act

• A culmination of many previously identified issues:
  – HITECH – meaningful use
  – Reducing Readmissions
  – Medical Homes
  – Managing Transitions of Care

• But it’s not just about the Affordable Care Act (ACA)...

Informing Public and Policy

• Institute of Medicine
  – To Err is Human, 1999
  – Crossing the Quality Chasm, 2001
  – Preventing Medication Errors, 2006
  – And Other Related Topics

• Dartmouth

• Commonwealth

• Robert Wood Johnson Foundation

• Government Agencies: NIH and CDC

• Among others...
The Ultimate Goal: The Triple Aim

- Total Cost of Care
- Quality of Care
- Patient Experience
How will we accomplish the Triple Aim?

- Improved in-patient care efficiency
- Use of lower cost treatments
- Reduction in adverse events
- Reduction in preventable readmissions
- Improved management of complex patients
- Use of lower cost settings and lower cost providers

Hospitals and Specialists

Primary Care Practices

All Providers

- Improved practice efficiency
- Improved prevention and early diagnosis
- Reduction in un-necessary testing and referrals
- Reduction in preventable ER visits and hospitalizations
- Improved management of complex patients
- Use of lower cost settings and lower cost providers
- Lower total health care costs
How will we accomplish the Triple Aim?

Hospitals and Specialists
- Improved in-patient care efficiency
- Use of lower cost treatments
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- Reduction in preventable readmissions
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Primary Care Practices
- Improved prevention and Early diagnosis
- Improved practice efficiency
- Reduction in un-necessary testing and referrals
- Reduction in preventable ER visits and hospitalizations

All Providers
- Lower total health care costs
1 in 5
Average 30-day Readmission Rates

$17 billion
Preventable readmission costs

Question 1: Hospitals have no incentive to reduce readmission rates:

• Myth
• Truth
• Unsure
Question 1:
Hospitals have no incentive to reduce readmission rates:

• Myth
1% - 3% Penalty

Burton R. “Health Policy Brief: Care Transitions,” Health Affairs, September 2012
## Typical Hospital Utilization

<table>
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<th>ED visits, 2011</th>
<th>0</th>
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<th>2</th>
<th>3 to 4</th>
<th>5+</th>
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<td>Normal Range of Utilization</td>
<td></td>
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<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>Potential High Utilizers</td>
<td></td>
</tr>
<tr>
<td>2 to 3</td>
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<td></td>
<td></td>
<td>Potential High Utilizers</td>
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<td>4 to 5</td>
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<td>6 to 7</td>
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<td>8 to 9</td>
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<tr>
<td>10+</td>
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<td></td>
<td></td>
<td>Inpatient High Utilizers</td>
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</table>

Camden Coalition
Diabetes and Inpatient Admissions

• Diabetes was primary or secondary dx in more than 5.3 million hospital discharges in 2010.
• At any given time, 1 in 3 or more in-patients have hyperglycemia, typically caused by diabetes.
• Increased length of stay (LOS) and decreased hospital revenue.
  – 5.3 days in 2008, compared with 4.4 days for patients without diabetes.

Diabetes complications that can result in Medicare penalties

- **Manifestations of poor glycemic control:**
  - hypoglycemic coma, acidosis

- **Falls and trauma:**
  - Peripheral neuropathy increases risk
  - Due to hypoglycemia and resulting confusion, vision problems and loss of consciousness

- **Surgical-site infections** -- hyperglycemia increases risk of infection

- **Pressure ulcers** -- Due to neuropathy and/or poor circulation

It’s more than managing glucose

"Hospitals should do appropriate discharge planning for diabetic patients so the patient gets discharged to the next care setting with the right education and the right follow-up care, so they've got that continuation of care outside the four walls of the hospital...”

Hazel R. Seabrook, a managing director at Huron Consulting Group, Chicago.
Case Presentation: Charley

- 55-yo Caucasian male
- Medicare/Medicaid coverage
- Lives alone
- Takes 12 medications daily
- 6 months prior to enrollment
  - 9 ED visits & 6 inpatient stays
  - Hospitalized on average every 45 days
- Complex chronic conditions
  - ESRD
  - Diabetes
  - Hypertension
  - Hyperlipidemia
  - Peripheral vascular disease
  - Retinopathy
  - Sleep apnea
  - Severe neuropathy
Discharge Planning Challenges

- Pressures to discharge patient early
- Shorter hospital stays
- Competing priorities
- Lack of PCP
- Nursing workload
- Lack of diabetes educator
- Weekend discharges

Strategies for Effective Discharge Planning for Hospitalized Patients With Diabetes. AACE
Charley’s Interaction with the Care System

- Meals
- Transport
- Durable Goods
- Home PT/OT
- Home Care
- Hospital #1
- Hospital #2
- Sub-Acute Rehab
- Pharmacy
- Dialysis
- Nephrology
- Ophthalmology
- PCP
- Pain Mgt
- Sleep Clinic
- Cardiology
- DSME
Building Community Care Teams

Health Care Organizations

PCP/HCH
PCP/HCH
PCP/HCH
PCP/HCH
PCP/HCH
PCI/HCH
PCI/HCH
PCI/HCH
Health Policy MDH and DHS
Correctional systems
Public Health WIC, Maternal/Child health
Employers
Assisted Living
Adult Day Care
Nursing Homes
Dental
Family Services
Housing Services
Community Mental Health
Aging Services
Transportation
Faith Communities
Community Pharmacies
Home Care
Interpretive services
Schools
The Patient/Family, and their Care Team
Meals on Wheels
End of Life
Productive Interactions
Managing Transitions
Improved Clinical Outcomes and Patient Satisfaction, and Reduced TCOC
Informed, engaged consumer and family
Prepared, proactive Community care team
Charley is connected and engaged with his care team. Charley’s care team has the information and resources they need to work with him to create a care plan specific to his needs. Charley feels better, he is happier with his care and the total cost of his care has gone down.
In Spite of the Best Plans --

• Among Medicare beneficiaries readmitted to the hospital within 30 days of a discharge,
  
  — half have no contact with a physician between their first hospitalization and their readmission.

Care Coordination for Patients With Hyperglycemia/Diabetes

Create a collaborative team

Identify patients with hyperglycemia/diabetes

Develop an individualized treatment plan for each patient

Determine transition and discharge strategy

Monitor progress


Strategies for Effective Discharge Planning for Hospitalized Patients With Diabetes. AACE
Question 2:
Someone without diabetes who has hyperglycemia during a hospital stay that has resolved by discharge does not require any follow-up.

• Myth
• Truth
• Unsure
Question 2:
Someone without diabetes who has hyperglycemia during a hospital stay but is resolved by discharge does not require any follow-up.

• Myth
Discharge Planning Based on Diagnosis

• Temporary hyperglycemia
  – Resolves inpatient – schedule follow-up testing

• Previously diagnosed diabetes
  – Assess level of control
  – Adjust therapy as needed
  – Assess for complications
  – Outpatient follow-up

• Previously un-diagnosed diabetes
  – Plan to confirm diagnosis
  – Implement therapy and education
  – Schedule outpatient follow-up
Discharge Planning for Diabetes

• Diabetes discharge planning must begin early
• Assess pre-admission medications
• Assess pre-admission self-management skills
• Assessment of the patient’s diabetes knowledge and anticipation of needs after hospitalization
  – Include potential social barriers inhibiting access to visits or medications
• Use a multidisciplinary approach to coordinate care, services, and referrals needed upon discharge

Discharge Considerations

• What are the discharge plans for this patient?
  – Where will they be going?
  – Who will be there to support them?
  – Who needs to know what?

• What meds will they be taking?
  – Transition from inpatient meds to discharge meds

• When and where will follow-up take place?

• What education do they need prior to discharge?
Other Factors to Be Considered

• Physical/self-care limitations: vision, dexterity, ability to do ADLs
• Socioeconomic factors: financial issues, family support, transportation, access to healthy food
• Access to follow-up care: PCP, other HCPs
• Degree of glycemic control prior to admission
• Learning issues: language, cognition, competence related to diabetes self-management issues
Adults with any chronic condition hospitalized in past 2 years

Percent that did NOT:

- Know who to contact for questions about condition or treatment: 8%
- Receive written plan for care after discharge: 9%
- Receive instructions about symptoms and when to seek further care: 12%
- Have arrangements made for follow-up visits with any doctor: 28%
- Have any discharge gap: 38%

Data collection: Harris Interactive, Inc.
Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults. EL3, survey.
Patients’ Inpatient Education and Discharge Summary

• What health problems do I have?

• How should I take my medicine?
  – When do I take it?
  – What will it do?
  – What is it for?
  – How do I know if it is working?
  – Hypoglycemia recognition and treatment

• Other instructions
  – SMBG – How and when?
  – What are my treatment goals?
  – What about food and activity
  – What do I do if I get sick?

• Next steps
  – Where do I go for tests, medicine and appointments?
  – When do I need to be seen again?
  – Do I have another appointment?
    • If so, what are the date and time of the appointment?
  – Whom do I call if I have questions?
  – Are there phone numbers to call?
Discharge Planning for Diabetes: Insulin

• Upon discharge patient must demonstrate:
  – Injection technique
  – Familiarity with type of insulin, dosage, and the importance of correct timing with meals and activity
  – Arrange for follow-up ie:
    • PCP
    • Home health visits as needed
    • Appt with a diabetes educator
• SMBG –
  – how, when and target BG goals
• Hypoglycemia

Question 3:
PCPs generally receive adequate information about their patients’ ED visits and hospitalizations.

• Myth
• Truth
• Unsure
Question 3:
PCPs generally receive adequate information about their patients’ ED visits and hospitalizations.

• Myth
Lack of Communication with PCP

- In 2007, physicians had received a hospital discharge summary about their patients, and had it on hand, in only 12–34% of first post discharge visits.
- Even when discharge summaries are received, they often lack key information, such as test results, treatment course, discharge medications, and follow-up plans.
- It is worse for those patients without a PCP

Missing Information in DC Summaries

• Discharge medications (2%-40%)
• Treatment or hospital course (7%-22%)
• Diagnostic test results (33%-63%)
• Test results pending at discharge (65%)
• Patient or family counseling (90%-92%)
• Responsible hospital physician (16-27%)
• Follow-up plans (2%-43%).

Kripalani S. et al. Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians. Implications for patient safety and continuity of care. 2007 JAMA 297(8):831-841
Timely Discharge Information Required by the Receiving PCP

- Primary and secondary diagnoses
- Any diagnostic findings
- Dates of hospitalization, treatment provided, and a summary of hospital course
- Discharge medications
- Patient or family counseling
- Tests pending at discharge
- Details of follow-up arrangements
- Name and contact information of the responsible hospital physician
Understanding of Meds at Discharge

172 patients discharged from community-based teaching hospital with prescriptions for 1 or more new medications

<table>
<thead>
<tr>
<th>Understanding of Medication</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recalled being told of ANY possible adverse effects</td>
<td>11%</td>
</tr>
<tr>
<td>Could name ≥1 possible adverse effect</td>
<td>22%</td>
</tr>
<tr>
<td>Knew dose</td>
<td>56%</td>
</tr>
<tr>
<td>Knew medication purpose</td>
<td>64%</td>
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<tr>
<td>Knew medication name</td>
<td>64%</td>
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<tr>
<td>Knew dosing schedule</td>
<td>68%</td>
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<tr>
<td>Aware that new medications had been prescribed</td>
<td>86%</td>
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</tbody>
</table>

Adverse Drug Events - ADE

• “an injury resulting from medical intervention related to a drug.”

• Estimated 70% of patients experience an actual or potential unintended discrepancy at hospital discharge, which can then precipitate an ADE

• Preventable ADEs identified within hospitals, nursing homes, and ambulatory care range between 27% and 50%

• ADEs and issues with medication reconciliation across care settings are major drivers for hospital readmission

Bates et al., 1995; Classen et al., 1997; Gandhi, 2003; Gurwitz et al., 2003, 2005; Zhang et al., 2009.
2007-2009 National ADE data

• Frequency & rates of hospitalization of elderly after ED visits due to ADEs
• 5077 cases with 99,628 emergency hospitalizations for ADEs
• 2/3 hospitalizations due to unintentional overdoses
• Highest risk medications (implicated in 67% of hospitalizations)
  – Warfarin (33.3%) – alone or in combination with others
  – Insulins (13.9%) and oral hypoglycemic agents (10.7%)
  – Oral antiplatelet agents (13.3%)

Impact of Medication Reconciliation

• Inclusion of Med Rec in transitional care decreased the rate of med errors by 70% and reduced ADEs by over 15%\(^1\)

• Reduced discharge medication errors:
  – from 90% to 47% on a surgical unit and
  – from 57% to 33% on a medical unit of a large academic medical center\(^2\)

Question 4:
There is no reimbursement for doing transition care.

- Myth
- Truth
- Unsure
Question 4: There is no reimbursement for doing transition care.

• Myth
Medication Therapy Management

• Medication history
  – up-to-date listing of all prescription and over-the-counter
  – medications, herbal supplements and vitamins

• Medication Reconciliation
  – comparison of previous medication list to new one
  – resolve discrepancies
  – identify and resolve medication related problems
  – should occur whenever there is a care transition, or change in medications or diagnosis

• Medication Adherence

http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM.html
Transitional Care Management Services (TCM)

- The services are required during transition to the community setting following defined discharges;
- The HCP accepts care of the beneficiary post-discharge without a gap;
- The HCP takes responsibility for the beneficiary’s care;
- The beneficiary has medical and/or psychosocial problems that require moderate or high complexity medical decision making.
- The 30-day TCM period begins on the date of discharge and continues for the next 29 days.

HCPs that may furnish TCM services:

• Physicians (any specialty); and
• And the following practitioners who are legally authorized and qualified to provide the services in the State in which they are furnished:
  – Certified nurse-midwives;
  – Clinical nurse specialists
  – Nurse practitioners; and
  – Physician assistants.

  Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf
TCM services are furnished following discharge from one of the following inpatient hospital settings:

- Inpatient Acute Care Hospital;
- Inpatient Psychiatric Hospital;
- Long Term Care Hospital;
- Skilled Nursing Facility;
- Inpatient Rehabilitation Facility;
- Hospital outpatient observation or partial hospitalization; and
- Partial hospitalization at a Community Mental Health Center.

The beneficiary must be returned to his or her community setting, such as:

- His or her home;
- His or her domiciliary;
- A rest home; or
- Assisted living.

During the 30 days following discharge, the following components must be furnished

- An interactive contact;
- Certain non-face-to-face services; and
- A face-to-face visit.

[Website Link]

When distance is an issue...

• eEmergency technology provided services to more than 9,100 patients to date.
• Because of eEmergency care, 860 patients who would have transferred were able to receive care in their own communities.
• Transfers avoided because of eEmergency have saved more than $6.8 million in transfer costs.

Avera Health System
Telehealth
Summary

• Effective inpatient to outpatient transition of care is a national priority

• An effective diabetes discharge plan includes:
  – Inpatient DSME as appropriate with referral to outpatient DSME
  – Clear post-discharge care plan to patient
  – Discharge plan is accessible to outpatient practitioners

• Identification of patients’ social barriers needs to take place for effective discharge planning

References for slide 40


Thank you very much!
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