Diabetes Transition Planning

University of Illinois at Chicago

Purpose

- To present a transition plan for a participant with diabetes who will transition from a nursing home to the community.
- Included are examples of a plan that could be used and adapted for participants with diabetes.
- The plan does *not* contain information and/or management of conditions other than diabetes.

Case Study

- Ann is a 52 year old female with diabetes mellitus type 2.
- Her *other* medical conditions include:
  - Diabetic retinopathy, diabetic neuropathy, arthritis, obesity, hypertension, hyperlipidemia (high cholesterol) and CAD (coronary artery disease).

Case Study-Medications

- Lantus 20 units at bedtime (long-acting insulin)
- Metformin 1000 mg BID (twice a day)
- Neurontin 600 mg TID (three times a day)
- Lisinopril/HCTZ 20/12.5 mg daily
- Simvastatin 40 mg daily
- Aspirin (ASA) 325 mg daily
- Tylenol 500 mg 2 every 4-6 hrs prn (as needed)

MFP Transitions

Case Study

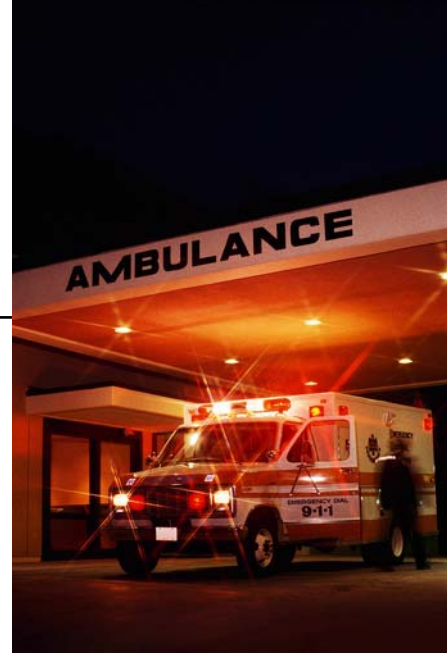
- Ann was transferred from the hospital to Maple Nut Nursing Home after she was hospitalized for a blood sugar level of 750. Her blood sugars were frequently high--over 200.
- During Ann's stay at Maple Nut Nursing Home she developed a wound on her buttocks. Ann developed a heel wound shortly after her buttocks' wound healed.

Case Study: **Sensory needs/impairments:**

- Glasses for decreased vision secondary to the diabetic retinopathy. She is unable to fill up her own insulin syringes.

- A walker for decreased mobility secondary to difficulty getting around due to weight issues and diabetic neuropathy (lost sensation/feeling in her feet).
- Wound care and supplies on her heel wound. She has difficulty reaching and seeing her heel wound.

Case Study



- **Hospitalizations** – admitted once 9 months ago only for hyperglycemia, blood sugar > 600.
- **Emergency room visits** – twice since admission to Maple Nut, last one 6 weeks ago related to a fall without using walker.

- **Other disciplines involved in care** –
  - Dr. Reynolds who is Ann's nursing home physician, but will not be managing her care after transition.
  - Physical therapy for mobility training and fall prevention.

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Diabetes-related Questions on the MFP Risk Assessment – Form H

Q # 18 – Does the participant need assistance/adaptive devices to manipulate the home environment?

Q # 38 - Is the participant having repeated unplanned emergency room visits?

Q # 42 – Does the participant have a history of falls or potential risk of falling?

Diabetes-related Questions on the MFP Risk Assessment – Form H

Q # 48 – Does the participant take nine or more medications (including over-the-counter medications)?

Q # 61 – Does the participant have diabetes?

Mitigation Planning: Q # 18 – Does the participant need assistance/adaptive devices to manipulate the home environment?

Risk Indicators include:

- Participant needs assistive equipment for ambulation or transfer (e.g. wheelchair, walker, cane, grab bar in tub or shower, elevated toilet seat, shower chair, etc.)

Why select this indicator?:
Participant does require a walker to get around. Grab bars and an elevated toilet seat are also necessary related to a previous fall in the bathroom.

MFP Transitions

Mitigation Planning: Q # 18 – Does the participant need assistance/adaptive devices to manipulate the home environment?

Mitigation Strategy - Arrange for the delivery of medical supplies, durable medical equipment, or other medical devices.

Mitigation Planning tasks include:

- TC will contact Joe's medical supply company and have walker, grab bars and raised toilet seat delivered before transition date. Contact person is Mike at 344-5656.
- TC will check the day of transition to make sure delivery has occurred.
- Participant will notify TC if she experiences any further problems with mobility. Will notify TC on a weekly basis for 1 month, then once a month.

Mitigation Planning: Q # 38 - Is the participant having repeated unplanned emergency room visits?

Risk Indicators include:

- participant has had more than 2 emergency room visits in the past year
- participant's medical condition or disability puts her at risk for unplanned emergency room visits

Why select this indicator? Ann has **fallen** twice in the last 9 months, she frequently has **elevated blood sugars** and she has a **wound**.

Mitigation Planning: Q # 38 - Is the participant having repeated unplanned emergency room visits?

Mitigation Strategies:

- Arrange for and monitor education on diagnoses/conditions.
- Arrange, verify and monitor appointment(s) with healthcare provider for new onset or worsening symptoms.
- Monitor participant for risk(s) and update care plan to prevent future accidental hospitalizations and ED visits.

Mitigation Planning: Q # 38 - Is the participant having repeated unplanned emergency room visits?

Mitigation Strategy– Arrange for and monitor education on diagnoses/conditions.

Mitigation Plan tasks include:

- TC will arrange for participant to receive diabetes education from _____. Contact person is Lisa at 345-9876.
- TC will check with participant to make sure education is occurring weekly x 4 weeks, then monthly. **TC to verify participant's comprehension of information.**
- Caregiver Leslie will accompany Ann to education sessions and update TC on status weekly.

Mitigation Planning: Q # 38 - Is the participant having repeated unplanned emergency room visits?

Mitigation Strategy– Arrange, verify and monitor appointment(s) with healthcare provider for new onset or worsening symptoms.

Mitigation Plan tasks include

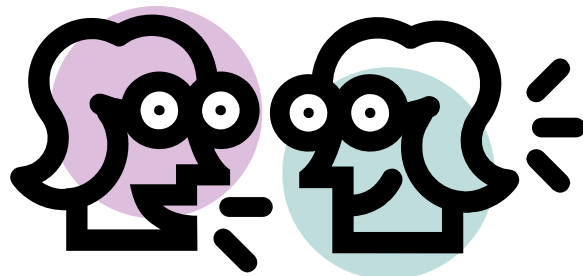
- Participant has her first visit with Dr. Smith at 555-8484 the day after transition.
- Participant will notify Dr. Smith of any increase in her blood sugar or **worsening** wounds. Blood sugar level of 300 is reportable same day. Continuous readings of >200 are also reportable. Any additional skin breakdown or wounds will be reported the same day.
- Participant will notify TC of any changes in symptoms or **changes in care** plan per Dr Smith.

Mitigation Planning: Q # 38 - Is the participant having repeated unplanned emergency room visits?

Mitigation Strategy - Monitor participant for risk(s) and update care plan to prevent future unplanned hospitalizations and ED visits.

Mitigation Plan tasks include:

- Participant will notify TC of any changes to her medication(s) or plan of care after doctors' visits.
- TC will check weekly with participant for any abnormal blood glucose readings or new skin breakdown and verify that Ann's doctor was notified.
- Participant and TC will make changes to plan of care at each visit, as indicated by status changes and doctor's recommendations.



Mitigation Planning: Q # 42 – Does the participant have a history of falls or potential risk of falling?

Risk Indicators include:

- participant has fallen in the last 31-180 days
- participant has risk for falling due to disabilities, medical conditions or history of falls
- participant has osteoarthritis, osteoporosis, or another condition resulting in decreased balance, control of limbs, or strength of limbs

Mitigation Planning: Q # 42 – Does the participant have a history of falls or potential risk of falling?

Mitigation Strategies include:

- Arrange for Personal Emergency Response System (PERS) and monitor delivery/installation

<u>Mitigation Plan Tasks include</u>:

- TC will contact Home Emergency Response System Provider, Susan is contact person, at 555-1212, and arrange for delivery and installation of PERS
- PERS will be delivered and installed on day of *or* a day prior to transition
- Monitoring will occur by TC/caregiver (name) on day of transition, then in one week

MFP Transitions

Mitigation Planning: Q # 48 Does the participant take nine or more medications (including over-the-counter medications)?

Risk Indicators include:

- Participant is taking 5 or more prescription medications.

Mitigation Strategies include:

- Arrange for review of medications with a healthcare provider and monitor.
- Develop and monitor a medication list and schedule for taking medications and reordering medications with the participant and/or caregiver.

Mitigation Planning: Q # 48 Does the participant take nine or more medications (including over-the-counter medications)?

Mitigation Strategy - Arrange for review of medications with a healthcare provider and monitor.

Mitigation Plan tasks include:

- Participant will notify TC if she does not understand or has questions regarding medications.
- Participant will contact Dr. Smith for appointment with any questions or concerns regarding medications.
- Participant will take updated medication list (Form G) to **ALL** appointments with healthcare providers.
- TC will check with participant to verify understanding of medication regime at each visit, on transition day and then weekly x 1 month.

Mitigation Planning: Q # 48 Does the participant take nine or more medications (including over-the-counter medications)?

Mitigation Strategy - Develop and monitor a medication list and schedule for taking medications and reordering medications with the participant and/or caregiver.

Mitigation Plan tasks include:

- TC will complete Form G (MFP Medication Chart) and provide a copy for participant on day of transition.
- Participant will notify TC of any changes in medication regime after each MD visit.
- Participant and TC or caregiver (if applicable) will update medication chart after each change in medication.
- Home care nursing will fill up insulin syringes so Ann can self-inject for **first** month. Afterwards identified caregiver will fill syringes.
- TC will verify, at each visit with participant, any changes in medication regime. Weekly x 1 month.

Mitigation Planning: Q # 61 – Does the participant have diabetes?

Risk Indicators include:

- Participant is unable/refuses to perform regular blood sugar testing.
- Participant's daily blood sugars are significantly over the recommended value.
- Participant has difficulty self-administering injections.
- Participant is unable/refuses to perform daily foot checks. Participant has not gotten or is unable to get yearly eye exams.

Mitigation Planning: Q # 61 – Does the participant have diabetes?

Mitigation Strategies include:

- Arrange, verify and monitor appointment(s) with healthcare provider for new onset or worsening symptoms.
- Arrange for and monitor home care nursing.
- Arrange for yearly eye exam and monitor for follow-through.
- Educate caregiver or participant to keep a daily log of blood sugars and monitor for follow-through.
- Provide participant and/or caregiver with a list of emergency contact service personnel.

Mitigation Planning: Q # 61 – Does the participant have diabetes?

Mitigation Strategy- Arrange, verify and monitor appointment(s) with healthcare provider for new onset or worsening symptoms. (See risk question # 38.)

Mitigation Plan tasks include:

- Participant will arrange for regular appointments with Dr. Smith for diabetes monitoring and management.
- Participant needs yearly dilated eye exam with M.D. ophthalmologist, regular podiatry appointments, and wound care specialist appointments as needed. She will call to schedule the first month appointments after transition day.
- Participant will keep track of appointments on her calendar.
- TC will inquire as to how appointment went with each contact and reinforce the importance of regular diabetes management.

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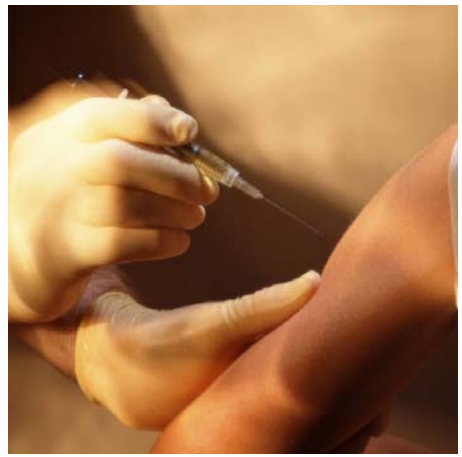
Mitigation Planning: Q # 61 – Does the participant have diabetes?



Mitigation Strategy- Arrange for and monitor home care nursing.

Mitigation Plan tasks include:

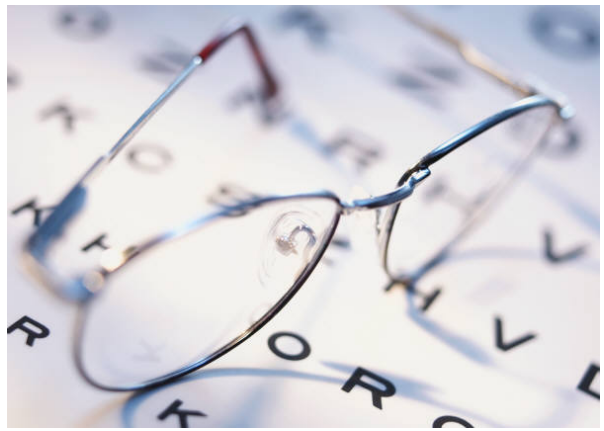
- TC will arrange for home health nursing to start upon transition. Referral can be made by nursing home staff with attending physician orders.
- Home health nursing will provide education on diabetes management, medications, wound care, skin checks especially feet, fill insulin syringes and instruct caregiver/family member of filling syringes.
- TC will contact home care nursing, prior to transition, to determine when home visits will start.

Mitigation Planning: Q # 61 – Does the participant have diabetes?

Mitigation Plan tasks (continued):

- At each contact TC will discuss with participant importance of home health nursing in management of diabetes.
- Include name of home health agency, contact number and phone number.
- Home health nursing will perform initial wound care management and then instruct participant/caregiver on any additional wound management needed.
- Visits will be daily and then weekly according to eligibility guidelines.

Mitigation Planning: Q # 61 – Does the participant have diabetes?



Mitigation Strategy- Arrange for yearly eye exam and monitor for follow-through.

<u>Mitigation Plan tasks include:</u>

- Participant will contact ophthalmologist's office and make appointment for **<u>diabetic</u>** eye exam in 1st month after transition, then notify TC of ophthalmologist's name, phone number and date of appointment.
- TC will verify with participant that exam date is scheduled.
- Participant will notify TC results of appointment, any changes to plan of care, and/or when follow-up appointment is needed.

Mitigation Planning: Q # 61 – Does the participant have diabetes?

Mitigation Strategy- - Educate caregiver or participant to keep a daily log of blood sugars and monitor for follow-through.

Mitigation Plan tasks include:

- TC or home care nursing will instruct participant/caregiver on importance of daily blood sugar monitoring and recording. They will review written instructions of what actions participant should take if blood sugar reading is high or low.
- Participant/caregiver (name) will record daily blood sugar checks in log book, on calendar or in a notebook.
- Participant will take record to each appointment with Dr. Smith and make record available to home health nurse and TC at each contact.

Mitigation Planning: Q # 61 – Does the participant have diabetes?

Mitigation Strategy- Provide participant and/or caregiver with a list of emergency contact service personnel.

Mitigation Plan tacks include:

- TC will complete Forms K (MFP 24 Hour Back-Up Plan) and L (Personal Resource List) prior to transition.
- TC will provide copy to participant on day of transition.
- TC and participant will both be responsible for updating forms with changes in caregivers and/or providers.

Follow-Up

- Follow-up for a participant with diabetes needs to be proactive.
- A participant's blood sugar can get very high or very low in a just an hour or two.
- Participants need someone available or need the ability to: check their own blood sugar, administer insulin, call for further instructions if blood sugar is too high or too low, and (in Ann's case) monitor feet and skin for changes, on the day of transition.
- If the participant is not able to perform tasks themselves, it is necessary to have home health nursing there on that first day or have a family member/caregiver who has the knowledge to manage diabetes.

MFP Transitions

Questions

- If you have questions about this module, contact your UIC Pod leader.