Discharge Strategies to Ensure a Safe Transition from Hospital to Home

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Disclosure to Participants

• Conflict of Interest (COI) and Financial Relationship Disclosures:
  – Brian Ulmer, MD – Speaker’s Bureau: Novo Nordisk; Advisory Board: Monarch Medical Technologies
  – Bridget Bundy – none
• 83 yo F with h/o T2D (A1c 7.6%) on glipizide 5 mg daily and metformin 1000 mg bid admitted with COPD exacerbation. While in hospital, oral medications discontinued and treated with detemir 28 units daily and aspart ICR 10/correction 35. Patient sent to ED from PCP office 3 days following discharge with BG above 500 mg/dL. How could have this been avoided?

#AADE

Challenges Encountered at Discharge
• Limited time
• Lack of patient interest/attention
• Formulary issues/medication reconciliation
• Provider knowledge
• No established follow-up
• Poor health care literacy/financial resources

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Strategies to Ensure a Safe Discharge
• Identify high-risk patients early
• Work with providers to establish appropriate discharge plan
• Train staff and have resources accessible if formal diabetes education unavailable
• Remain in contact with patients at high-risk for readmission following discharge

#AADE
Strategies to Ensure a Safe Discharge

- Confirm insurance coverage for medications/supplies
- Provide clear written instructions
- Schedule follow-up and communicate discharge plan to outpatient provider

Diabetes Education Decreases Risk of Readmission

- Inpatient diabetes education associated with lower 30-day readmission among patients with A1c > 9% (11% vs 16%)\(^1\)
- 30-day readmission rate decreased from 20.1% to 15.1% in patients seen by diabetes educator\(^2\)

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\(^1\)Healy SJ et al. Diabetes Care 36:2960-2967

\(^2\)Drincic A et al. Journal of Clinical & Translational Endocrinology 8:29-34
# Follow Up Calls

**Total Follow Up Call Data**

- 121 calls made Jan-May 2019
- 86 Completed (71%)
- 187 calls in 2018
- 67% completed

### Call Completion Data

<table>
<thead>
<tr>
<th>Month</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
</tr>
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<tr>
<td>Calls completed</td>
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<td>17</td>
<td>13</td>
<td>17</td>
<td>17</td>
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<td>Call completed %</td>
<td>62.9%</td>
<td>77.3%</td>
<td>72.2%</td>
<td>94.4%</td>
<td>65.4%</td>
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Follow-Up Phone Call Template

1. Did you receive everything you need to take care of your diabetes?
2. Did you get your medications at the bedside or did you pick them up at a pharmacy?
3. Have you been checking your blood sugars? What are they running?
4. Any blood sugars >200? >300? 
5. Have you made your follow-up appointment yet? When is it?
6. Were you satisfied with your diabetes care here in the hospital?
7. Do you feel like you are able to adequately care for your diabetes at home?
Follow Up Calls
January 2018-May 2019

Follow Up Call Questions (Jan-May 2019)

Issues Reported to DE on Follow Up Call (Jan-May 2019)

- 13 had issues with Insulin
  - Prescription issues: 7
  - Formulary: 1
  - Cost: 5
- 14 had issues with supplies
  - Prescriptions not given at discharge: 12
  - Cost: 1
  - Unknown: 1
- 4 patients had confusion with directions on insulin
- 4 did not have follow up appointments made
Prescribing Issues

- Encourage providers to E-prescribe over paper prescriptions
- Diabetes Supplies are not listed in the medication section of EMR
- Medicare requirements
  - Must have “pen” on Rx or it defaults to vial
- Formulary Issues

Old Retail Scripts

- Had ALL insulin options and diabetes supplies
- Pharmacies reported missing items from these sheets
- Medicare would no longer accept scripts that were not being E-scribed or on “blue” scripts

New Prescription Stickers for Supplies
Prescription Assistance

- “Meds to Bed”
- In house pharmacy
- 340B program
- Charity Medications

Transition Clinic

- Takes insured and uninsured
- Can see patients within 3-5 days
- Appointment times are extended for education
- Access to EMR system
- Will continue to follow patient seen by Endocrinology or Primary Care
- NP’s have access to education materials
Remote Care Monitoring

What they do:
- Monitoring recently discharged patients via technology
- Daily calls for two weeks, and then as needed
- Medication reconciliation
- Monitoring of biometrics
- Standardized care plans
- Connect patient and provider
- Continued referral to ancillary services as needed

Goals:
- Reduce 30-day readmission rates
- Assist in managing complex chronic diseases
- Assist in identifying barriers of care
- Real time collaboration with providers

Outcome Data for Remote Care Monitoring

- ED Utilization
  - 40.4% reduction in 30 Day ED utilization - Jan’19

- Readmissions
  - 87.5% 30-Day All Cause readmission reduction post enrollment Jan’19
  - 100% 30-Day Same Cause readmission reduction post enrollment Jan’19

- Patient Satisfaction
  - 98.8% Patient satisfaction with program – “I would recommend the program to family/friend” – FY19