

Diabetes Care Program for Older Adults
Eileen M. Koons, MSW, ACSW

Program Setting: Huntington Memorial Hospital (HMH) is a 636 bed non-profit community-based teaching hospital founded in 1892, located in Pasadena, California.

The Problem: Thirty-day readmission rates for older adults on Medicare with diabetes as primary or secondary diagnosis are significantly higher than they are for the HMH general Medicare population (19% versus 11%). Further, 57% of the admissions exceed the geometric Medicare length of stay (LOS) by 5.4 days on average, costing HMH \$3.4 million annually.

Target Population and Plan: This program aims to improve outcomes for community-dwelling diabetic patients age 65+ with Medicare and reduce costs to the organization by:

1. Working with HMH medical residents and hospitalists to conduct an initial 4-month feasibility study to promptly identify and refer target patients, identify variables that contribute to extended hospital stay, and strategize a solution to reduce LOS.
2. Improving the patient's care transition from hospital to home by (a) adapting the Coleman Care Transitions InterventionSM protocols previously tested by HMH and (b) standardizing the physician communication hand-off from hospital to post-hospital care.
3. Providing transition coaching for four weeks: A program social worker will make an initial home visit followed by weekly follow-up phone contacts. If needed, a diabetes educator will make 1-2 home visits for disease self-management education, and the patient may be referred for longer term care coordination to address resource and care needs.
4. Working with HMH's Six Sigma Quality Improvement Program to (a) conduct a detailed data analysis to develop benchmark data and appropriate outcomes and (b) track program costs and patient outcomes to validate the business case for sustainability.

Outcomes: The program is designed to reduce the target population's (1) length of stay and (2) incidence of 30-day readmissions compared with prior 12 months. In addition, patient satisfaction with transition services and confidence in disease self-management will be measured at baseline and 3 months after enrollment using Coleman's *CTM-15* and Lorig's tool *Self-Efficacy to Perform Self Management Behaviors*, respectively.

Sustainability: Once the initial program phase is completed, HMH will conduct an analysis to determine whether the program advances quality and financial goals. If successful, the outcomes tracking mechanisms will be established to ensure program gains are sustained.

Please [email Eileen](#) with any questions or comments regarding this project.